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Illinois Medical Journal

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY



31st. nnual convention highlights


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IMJ illinois medical journal

volume 140, number 1 July, 1971

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REGISTERED AIA MEDIA DATA FORM



the presidents page

(Editor's note: In his inaugural address May 19, Dr. L. T. Fruin, Normal, new president of the Illinois State Medical Society, described himself as an "angry physician." He galvanized physician listeners—and the news media—by lashing back at critics of medicine. Stories based on his speech appeared in the Chicago Tribune, Chicago Daily News, Chicago Sun-Times and other Illinois newspapers. Numerous requests for his speech include one from the "National Observer." Because of its impact, Dr. Fruin's speech has been condensed for use in this month's IMJ *Presidents Page.)*

"I'm an angry physician!

"I'm angry at self-serving politicians who exaggerate our health care problems . . . politicians who promise much but deliver little . . . politicians who are self-appointed appraisers of talents which they do not possess. . . .

"I'm angry at labor leaders who claim that we don't known HOW to deliver health care . . . labor leaders who proclaim featherbedding is an indisputable right.

"I'm angry at patients who expect a magic cure for years of their own neglect . . . patients who smoke too much, drink too much, eat too much, demand too much and care too little about who provides . . . and pays . . . for their health care.

"I'm angry at being part of a society in which physicians alone are blamed for health care problems in poverty areas.

"Medicine didn't create the poverty pocket that represents the heartland of Chicago. No amount of medical care is going to cure ghetto health problems unless legislative healers provide the housing, the food, the education, the employment, the personal security and thus, the dignity this area needs. Then and only then will this area be able to attract doctors.

"The cost of health care is one of the burning issues of the day. It has shouldered aside concerns such as the war, law and order, environmental pollution, racial strife and decorum on the campus.

"History shows that when governments are confronted with problems they cannot solve, they seize upon one issue which they can label as free. In America today, the promise is 'free' medical care.

"Yet they neglect to point out the poor, bedeviled taxpayer will have to bear the costs!

"Yes, I'm angry!

"In much of what has been written and spoken about the costs of health care there is the implication that high costs are the result of physician mismanagement and greed. Yet we get 18 cents or less of every government health care dollar."

Criticism of health care plans

Dr. Fruin then described and criticized health care plans pending before Congress which were authored by "health care seers" who completely ignore the doctor shortage.

"It would be cruelty of the worst sort to withhold more taxes and promise even more health care services that cannot possibly be delivered. Yet, that's what they propose.

"The federal government should place all possible emphasis on increasing the number of physicians and allied health delivery personnel. When this happens, many of today's health problems will disappear."

Dr. Fruin dismissed those national health care plans—such as the one proposed by Senator Kennedy—as being the result of "poor advice." That advice was "certainly not from the overworked and overwrought practitioner of medi-

(Continued on page 79)

BLUE SHIELD REPORT FOR *Illinois Physicians*

ALTERNATIVE HEALTH CARE DELIVERY SYSTEMS

The following policy statement on alternative systems of health care delivery was adopted by the Board of Trustees of the Blue Shield Plan of Illinois Medical Service.

"Over the years, the role of Blue Cross and Blue Shield, as non-profit community service organizations, has been to provide the public with a prepayment mechanism through which it might obtain the highest quality health care. Blue Cross and Blue Shield make available a variety of benefit programs from which consumers can choose the type of coverage which best meets their needs.

"Following experimentation and evaluation, innovations in health care prepayment traditionally have become part of Blue Cross and Blue Shield programs. This desire to innovate has been and will continue to be the foundation and strength of the voluntary health care system.

"While strengthening their existing programs, Blue Cross and Blue Shield desire to maintain their traditional leadership roles through continued experimentation with evolving forms of health care delivery and financing systems. Implicit in any offering of alternative systems in the delivery of health care is the free exercise of consumer options and physician control of their professional activities.

"Major current developments which offer promise for either effectiveness or economy of health care delivery include medical society foundations for medical care, health maintenance organizations, health care corporations, prepaid group practice, surgical care centers, model cities projects, and neighborhood health centers.

"Blue Cross and Blue Shield fully intend to continue to make available to the public their usual benefits with delivery and financing following traditional patterns. However, in addition to encouraging wider participation in their present programs, Blue Cross and Blue Shield plan to assist providers of services in the development of alternative approaches to health care delivery and financing. They also plan to implement these efforts by offering the public, as an option to existing Blue Cross and Blue Shield benefit programs, the opportunity of electing to receive benefits through alternative systems which meet the Blue Cross and Blue Shield standards. Blue Cross and Blue Shield feel that by making these choices available, they can better serve the community.

"Blue Cross and Blue Shield welcome expressions of interest from physicians and their medical societies, from other providers, employers, unions and other parties who desire to participate in these approaches to quality health coverage."

BLUE SHIELD AGE RATING TO EQUALIZE RATES

Blue Cross and Blue Shield recently adopted a new method of equalizing rates for our non-group subscribers. The new method, called Age Rating, became effective July 1.

Age Rating is based on our experience that the use of health care benefits increases with a person's age. Under the previous method of equal rates for all age groups, the younger subscribers were subsidizing the health care benefits used by the older ones. Under the age rating system, those age groups which make more than the average use of Blue Cross and Blue Shield benefits will pay slightly more for their health care coverage while those age groups which make less than the average use of their benefits will pay slightly less.

A combination of an increase in hospital and medical costs and the use of benefits by the group necessitates the initiation of the age rating system for non-group members. These members use their benefits more frequently than any other group enrolled by Blue Cross and Blue Shield. In the first two years of our Health Services Plan, the newest of our three non-group certificates, more than 38 million dollars in benefits were paid and our experience has been that use of this and the other plans is still increasing.

Blue Cross and Blue Shield Executive Vice President Robert M. Redinger says of the new rating policy, "Age rating . . . affects only 7% of our more than three million members - - - or approximately 210,000 people in Illinois. Those in the older age groups received considerable rate increases because their usage of Blue Cross and Blue Shield benefits is roughly three times that of younger non-group subscribers. . . . Younger members were, in effect, subsidizing our older subscribers under our former rate structure. We sincerely believe our new method of age rating will tend to stabilize rates and, in the long run, be helpful to all members."

(This is not an advertisement)

ASK BLUE SHIELD

• • • ABOUT MEDICARE

Coverage and Limitations For Drugs and Biologicals

Payment can be made under Part B Medicare for drugs and biologicals if they cannot be self-administered; they are reasonable and necessary for the diagnosis and treatment of the illness or injury for which they are administered; they are not immunizations; and they meet all the general requirements for coverage of items as "incident to" a physician's service. For example, the drug must be administered by the physician, or by his nurse under his personal supervision, and the charge, if any, for the drug must be included and itemized in the physician's bill.

Whether a drug or biological is of a type which cannot be self-administered is based on the usual method of administration of the *form* of the drug or biological furnished by the physician. Thus, pills or other oral medications are excluded as these forms are self-administered. Similiarly, injections given by a physician of a drug which is usually self-administered, such as insulin, are excluded except when administered to a patient in an emergency situation. However, injections given by a physician of a drug which is usually not self-administered are not subject to this exclusion, regardless of the availability of an oral form, since the drug was not self-administerable in the form in which it was furnished to the patient.

Vaccinations or innoculations are excluded as "immunizations" unless they are directly related to the treatment of an injury or direct exposure to a disease or condition. Preventive immunization is not covered. Influenza injections are considered preventive treatment and are excluded from coverage without regard to a patient's particular susceptibility to influenza.

The injection must be necessary and reasonable for diagnosis or treatment of an illness or injury. Injections given for the "general good and welfare of the patient" are not considered a covered service according to Medicare regulations.

Payment will not be made for injections which are not considered by accepted standards of medical practice to be indicated as a *specific* or *effective* treatment for the particular condition for which they are given. Vitamin B-12 and Endrate are two injections which cause some confusion. The Social Security Administration has now determined specific conditions and diagnoses for which these are considered covered injections.

Vitamin B-12 injections are considered specific therapy for:

Certain anemias—pernicious anemia; megaloblastic anemias; macrocytic anemias; fish tapeworm anemia.

Certain gastrointestinal disorders—gastrectomy; malabsorption syndromes such as sprue and idiopathic steatorrhea; surgical and mechanical disorders such as resection of the small intestine, strictures, anastomoses and blind loop syndrome.

Certain neuropathies — posterolateral sclerosis; other neuropathies associated with pernicious anemia; during the acute phase or acute exacerbation of the following: multiple sclerosis, trigeminal and glossopharyngeal neuralgia, neuropathies of malnutrition and alcoholism, tabes dorsalis, causalgia, postsympathectomy parasthesias, diabetic neuropathies and herpes zoster and other inflammatory neuritides not due to mechanical or traumatic etiology.

Endrate is considered a covered injection when administered to selected patients for the emergency treatment of hypercalcemia and for the control of ventricular arrhythmias and heart block associated with digitalis toxicity. It may also be covered if indicated as necessary in the preparation of hypercalcemic patients for emergency surgical procedures and for temporary symptomatic treatment of patients with sclerodermas.

NOTICE
Where To File Part B Medicare Claims

The Social Security Administration reassigned Illinois counties to the two Part B Medicare carriers, the Blue Shield Plan of Illinois Medical Service and the Continental Casualty Company, to equalize the volume of claims processed by each carrier.

Physicians in the counties of Will, Lake, Kane and DuPage were notified by letter that, as of July 1, 1971, administration of claims for Part B Medicare services by physicians whose offices are located in those counties will be handled by the Continental Casualty Company. Physicians whose offices are located in Will, Lake, Kane and DuPage Counties should submit their "Request for Medicare Payment" forms (SSA 1490) to the Continental Casualty Company offices **regardless of the area in which the services were performed.**

Physicians **whose offices are located in Cook County** should continue to submit their SSA 1490's to the Blue Shield Plan of Illinois Medical Service regardless of the area in which the services were performed.

Physicians who maintain more than one office should identify the office in or closest to the area where services were performed and file claims with the Part B Medicare carrier serving the area for that address. For example, if a physician has an office in Tinley Park, Cook County, and one in Downers Grove, DuPage County, and services were performed in Frankfort, Will County, he should identify the office nearest to where the services were performed. As his Tinley Park office is nearest to Frankfort, he should submit his claims to the Blue Shield Plan of Illinois Medical Service, the carrier for Cook County.

(This is not an advertisement)

Abstracts of Board actions Board of Trustees Meetings

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

May 15 - 19, 1971

Arlington Park Towers, Arlington Heights

Establishment of Foundations for Medical Care

Following action by the 1971 House of Delegates approving establishment of an Illinois Foundation for Medical Care, the Board of Trustees adopted these recommendations of the Health Care Financing Committee:

1. Four officers of ISMS—president, president-elect, and the first and second vice presidents—to be listed as incorporators of the Illinois Foundation for Medical Care.

2. Individuals on the 1971-72 ISMS Board of Trustees to serve as an interim Board of Directors for the Foundation until a permanent board is established.

3. Employment of American Health Systems (Geomet) as a consultant to the Foundation during its initial states of development. It is estimated that $30,000 will be needed to accomplish the first phase.

4. Authorization to finance Phase I of the Illinois FMC with a $30,000 loan from available Task Force on Physician Shortage funds, subject to approval of ISMS Educational and Scientific Foundation directors. This recommendation was amended by the Board to permit county medical society participation in the Phase I planning discussions contingent upon their sharing the consultative costs.

Representatives of county medical societies interested in forming local FMCs will be invited to participate in meetings of the interim board of directors.

In view of the House of Delegates' strong opposition to accepting federal tax money, the Board abandoned all efforts to obtain a U.S. government grant for developmental funds in the health care financing field.

Approve Joint Meeting of ISMS and CMS

Plans for merging the ISMS annual meeting and the Chicago Medical Society's annual clinical conference in 1972 have been approved. The joint meeting will be held March 8-11, at the Conrad Hilton Hotel, Chicago.

Orientation Meeting Planned for New Officers and Trustees

An orientation program to acquaint new officers and trustees with the workings of the Society has been planned to coincide with the July 17-18 meeting of the Board. A guide book for council and committee chairmen also was approved.

Dr. James Hartney Resigns from Board

The Board has accepted with regret the resignation of Dr. James B. Hartney as trustee of the Third District.

Abstracts of Board actions

Task Force on Physician Shortage

The Board has approved recommendations of the Task Force on Physician Shortage that the following contributions be made from Task Force Funds now in the ISMS Educational and Scientific Foundation:

$10,000 to the Medical Opportunities Program (MOP); $2,000 to the Council on Bio-Medical Careers; and $1,000 to ASPIRA, a program which encourages Spanish-speaking students to enter medical schools.

The Task Force recommended that no funds be contributed at this time to the Urban Doctors Program and that a request from the ISMS-IAA Student Loan Fund Board for $20,000 be withheld until more specific information is received.

Physician Assistants

The Board has agreed not to support legislation certifying categories of physician assistants as to the limits of duties which they may perform. This legislation differs markedly from a physician assistants bill previously endorsed by the Board which would allow the physician-employer to designate the assistant's duties.

Regional Trauma Centers

The Board voted to encourage county medical societies to cooperate with the Illinois Department of Public Health in developing regional trauma centers, but it stipulated that local boards of control should include representatives from the medical staff of each hospital where a trauma center is to be located.

Governor's Health Care Program

Dr. Franklin Yoder, director of the Illinois Department of Public Health, informed the Board that he had been officially designated as the primary channel of communication between the Administration and the medical profession. He also told the Board that the Governor had agreed that his recently announced health care program would be pluralistic in approach, allow free patient and free physician preference, and be in concert with national health goals. The Governor did not accede to the ISMS request that pending legislation to provide State control over hospital and nursing home expansions be withdrawn.

Peer Review

ISMS Legal Counsel has been requested to draw up guidelines for Peer Review Committees, giving particular attention to malpractice liability of committees performing peer review.

Rescinding its previous action, the Board endorsed a recommendation that post-operative care while in the hospital should be included in the physician's surgical fees. However, post-operative fees following dismissal from the hospital should be paid according to the usual and customary practices within the community.

editorials

Temperament and child rearing

In some homes when an infant cries excessively, one of the parents will make the observation, "He takes after you dear." If he sleeps well, the mother may proudly state, "He responds so well to my tender loving care." The age old argument of the effect of heredity or environment on the development of the child's personality is answered in an important paper by Doctor Alexander Thomas and his associates.[1]

This group has followed 141 children from birth through the tenth year and found that children differ in temperament from birth through childhood. Pediatricians, nurses and mothers are aware that the infant's personality manifests itself from birth. The authors point out that in the past twenty years many psychiatrists and psychologists have lost sight of this important fact.

The authors' data have led them to question the one sided influence of environment on the development of children. They noted that domineering, authoritative handling by parents would make one child anxious and submissive, while another child would exhibit defensiveness and antagonism. It was concluded that the important factor explaining these observations was the child's own temperament responding to the environment.

Three basic types of personalities were listed: 40% of the infants and children were classified as "easy"; 10% were described as "difficult"; 15% were categorized as "slow to warm up." The remaining 35% had a mixture of personality traits.

The authors caution against overemphasis of either heredity or environment in child rearing. What is important is the parents' understanding of the interaction between the child's own characteristic temperament and his environment. Doctor Thomas concludes that there is no one simple set of rules that parents can follow. Parents can be strict with one child and permissive with another, depending on the child's temperamental make-up.

Harvey Kravitz, M.D.

Reference

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Sorry—our mistake!

In the June issue of *IMJ*, the author's name was mis-spelled in the article, "Drug therapy in alcoholism" on page 606. The correct spelling is Vedad Oge, M.D.

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Electrocardiographic abnormality during non-exertional angina

By Hadi Dizadji, M.D., F.A.C.P., Manapurathu Mathew, M.D., Joseph A. Valaitis, M.D., and William Cernock, M.D., F.A.C.P./Chicago

The depression of ST segment as an electrocardiographic abnormality of angina pectoris during exercise test is well-established.[1] However, the electrocardiographic abnormalities during spontaneous angina pectoris have not been very well-studied.[2] Perhaps the unavailability of data describing these abnormalities is due to the fact that in most cases, tracings were obtained by mere chance rather than by design and continuous monitoring.[2,3] With the advent of coronary care units and the continuous monitoring devices, the physician will be able to evaluate more accurately the electrocardiographic changes during non-exertional angina pectoris. The information obtained by this method is important not only to better clinical interpretation, but also, possibly, for a proper evaluation of the nature of the disease.

The purpose of this report is to describe a patient who had chest pain with some characteristics of variant form of angina pectoris, described by Prinzmetal.[3] The electrocardiographic tracing of this patient illustrated a transient ST segment elevation compatible with diagnosis of an acute myocardial infarction.

Case Report

A 55-year-old, female Negro was admitted to the coronary care unit with a diagnosis of possible myocardial infarction. The chief complaint was severe retrosternal pain with no radiation, lasting for several minutes, one day prior to admission. Past history revealed no previous myocardial infarction; however, the patient stated that she had, for the past six years, repeated episodes of spontaneous chest pain, each episode lasting a few minutes.

The patient was 5'3", obese, and weighed 207 pounds. Blood pressure was 160/100. Fundoscopic examination revealed increased light re-

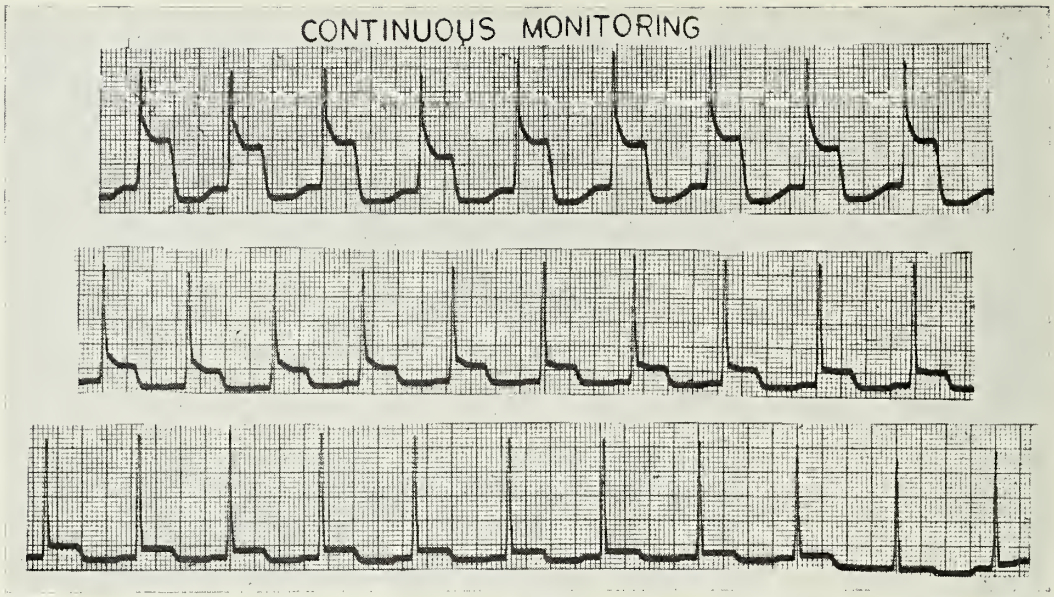
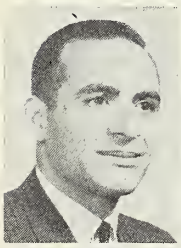


Fig. 1. Continuous monitoring tracing reveals ST segment elevation during non-exertional angina pectoris. As the pain subsided, ST segment returned to the iso-electric line. The tracings are continuous.

flex of the arteries and A-V nicking. No abnormal venous pulsations were observed at 45 degrees in the neck. The carotid arteries were normal. The examination of the heart revealed normal apical impulse, with no other abnormal precordial impulses. The first heart sound, aortic and pulmonic valves closure sounds were within normal limits. The patient had no congestive phenomena. There were no other pertinent abnormal physical findings in a complete examination. Electrocardiogram, taken on admission, revealed left ventricular hypertrophy and ischemia.

Forty-eight hours after admission, the patient, while resting, developed chest pain which lasted for a few minutes. Electrocardiogram taken at that time revealed ST segment elevation. As the pain subsided, ST segment returned to the iso-electric line similar to the pattern prior to the onset of pain (Fig. 1). Numerous and recurrent episodes of chest pains, each episode lasting for several minutes, continued during her hospitalization. Electrocardiogram taken during each attack persistently revealed ST segment elevation, with complete reversion to iso-electric line after the subsidence of pain.

Within 72 hours of hospitalization, it was decided that the patient did not suffer from myocardial infarction. This decision was based on clinical, electrocardiographic and laboratory data. The patient was discharged from the cardiac care unit, only to return to the hospital six months later with similar symptoms and elec-









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JOSEPH A. VALAITIS, M.D. (top right), is a resident at Loyola University Medical Center, and received his M.D. degree from Loyola University Stritch School of Medicine.

WILLIAM CERNOCK, M.D., F.A.C.P. (bottom right), is chairman of the Department of Medicine at Mercy Hospital and Medical Center. He received his M.D. degree from Loyola University Stritch School of Medicine.

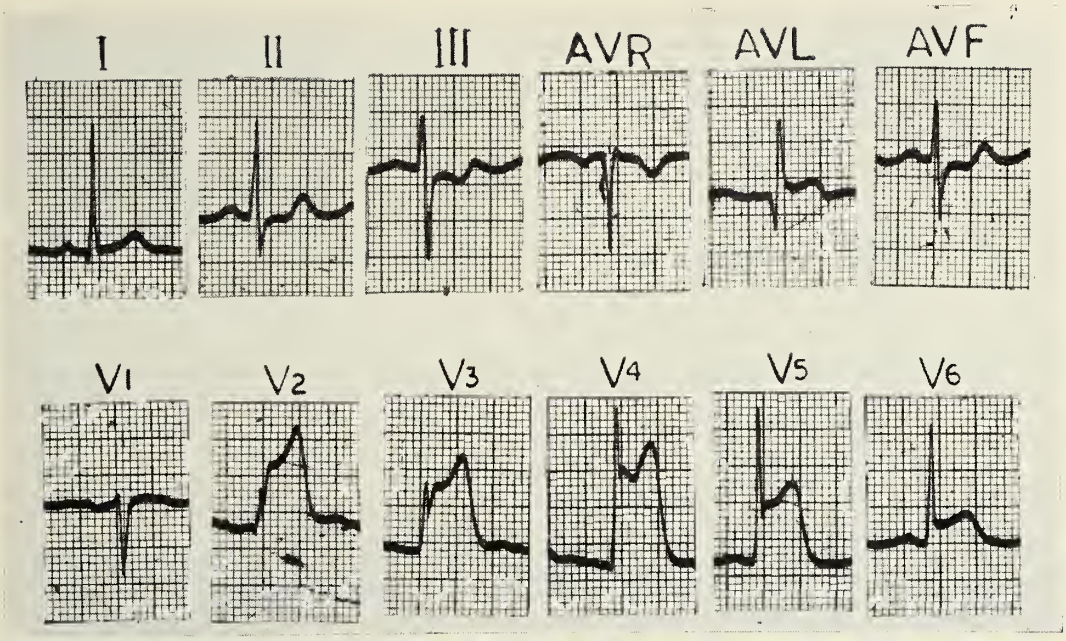


Fig. 2. Electrocardiographic tracing taken on second admission demonstrates a marked ST segment elevation during spontaneous angina pectoris.

trocardiographic findings. Figures 2 and 3 demonstrate electrocardiographic tracings taken on the second admission, with a marked ST segment elevation during pain and reversion to isoelectric line after cessation of pain, respectively.

Discussion

In 1933, Brow and Holman[4] reported a case of transient ST segment elevation during an attack of spontaneous angina. In 1959, Prinzmetal[3] described in detail the criteria for what is known as a variant form of angina pectoris, which included a transient ST elevation in electrocardiogram. Since the description of Prinzmetal, other investigators have reported cases whose electrocardiogram during angina demonstrated a pattern of injury, some associated with arrhythmia and conduction disturbances.[5,9]

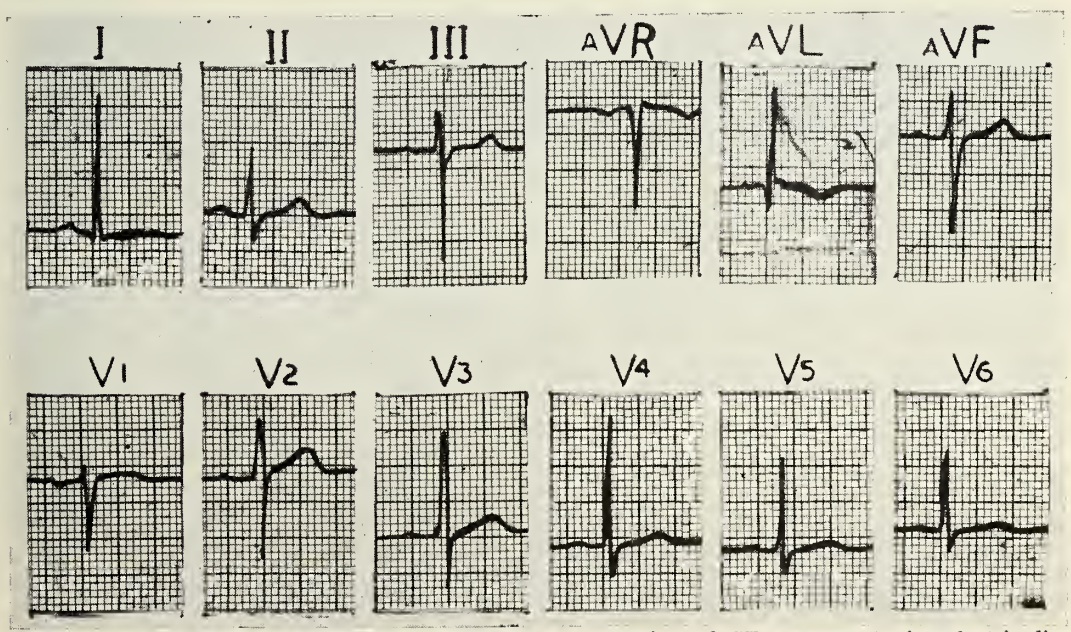


Fig. 3. Electrocardiographic tracing demonstrates reversion of ST segment to iso-electric line after cessation of pain.

The above case demonstrated some of the salient features described by Prinzmetal: (1) The chest pain occurred at rest; (2) It was not precipitated by any obvious emotional factors; (3) Electrocardiographic changes were characterized by ST segment elevation in leads, corresponding to the distribution of a large coronary artery; (4) Numerous recurrences of spontaneous angina were similar and shared the above features. In addition, during the patient's second admission, one of her electrocardiograms, during an attack of angina pectoris, demonstrated widening of QRS complex without ST segment elevation.

One striking difference between the classic angina and variant form of angina pectoris described by Prinzmetal, is the depression in the former and ST segment elevation in the latter. Prinzmetal has hypothesized that ST segment elevation in variant angina pectoris is due to increased coronary arterial tone in a previously narrowed vessel.[3,5] It has also been proposed by Prinzmetal, et. al., based on experimental evidence, that the following biochemical changes might develop during classical angina pectoris and variant form of angina. In classic angina pectoris with ST segment depression, there is an increase in intracellular potassium and carbohydrate metabolism and a decrease in intracellular sodium, whereas, in variant angina the opposite supposedly occurs, there being an increase in intracellular sodium and a decrease in intracellular potassium and carbohydrate metabolism. Although the above findings are plausible, further studies are obviously necessary for substantiation.

With the widespread usage of monitoring systems in coronary care units, it is hoped that more information regarding electrocardiographic abnormalities during non-exertional angina will be obtained and this information will, in turn, furnish valuable insight into the physiologic basis of the electrocardiographic abnormalities. The elevation of ST segment in the electrocardiographic tracing during spontaneous angina should be known to the physician to avoid the erroneous diagnosis of an acute myocardial infarction.

Summary

A patient with a variant form of angina pectoris was presented. Electrocardiographic abnormalities during spontaneous angina pectoris consisted of ST segment elevation, in contrast to well-known ST segment depression during exertional angina. It was suggested that continuous monitoring system in coronary care units might elucidate the exact incidence of electrocardiographic abnormalities during spontaneous and non-exertional angina pectoris. This information, in turn, might furnish valuable insight into the physiologic basis of electrocardiographic abnormalities and also avoid the erroneous diagnosis of an acute myocardial infarction. ◄

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the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine



Fig. 1

The patient was a 10-year-old boy who complained of pain of several months duration around the right hip joint which has gradually increased in severity. Physical examination revealed tenderness about the right pubic arch. A questionable mass was palpated at that time. What's your diagnosis?

1) Fibrous dysplasia
2) Ewing's sarcoma
3) Chronic osteomyelitis
4) Tuberculosis
5) Osteogenic sarcoma

(Answer on page 74)



surgical grand rounds

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of July 14, 1970.

Bladder diverticulum

Edited by John M. Beal, M.D.

Case Report:

Dr. Richard Hein: A 64-year-old, white male was admitted to Passavant with the chief complaint of weak urinary stream and nocturia for approximately one month prior to admission. The patient had marked hesitancy and was unable to urinate while standing unless pressure was applied to his perineum. His urinary stream had been weak and forceless. He voided every three hours during the day and one to two times per night. The nocturia had been present for about one year without change. Mucus was detected in his urine every three to four days and he had one episode of hematuria approximately three years earlier. At that time, investigation revealed only an enlarged prostate gland.

Physical examination was unremarkable except for a 1+ enlargement of the prostate on rectal examination. A two glass urine test revealed occasional white cells without red cells. Prostatic fluid contained innumerable white blood cells without lecathin bodies. Residual urine was 600 cc. Urine culture yielded proteus mirabilis, greater than 100,000 colonies per ml. An intravenous pyelogram and a cystogram were obtained.

Dr. Abram Cannon: The cystogram films are very interesting. The AP film demonstrated an irregular protrusion near the base but does not give a clue to the true size of the diverticulum (Fig. 1). On the oblique film, a large diverticulum which presents posteriorly and a little to the right of the bladder is demonstrated (Fig. 2). The post voiding film shows about as much contrast material remaining in the bladder as he had before he voided and the diverticulum appears to have emptied (Fig. 3).

Dr. Hein: Marked bladder neck contracture was detected when cystoscopy was performed and a diverticulum in the posterior cephalic aspect of the bladder was found. Minimal trabeculation of the bladder was present. The patient was taken to the operating room, where a diverticulectomy and wedge excision of the bladder neck and prostate were done. The diverticulum of the bladder was large, with a 2 cm. diameter mouth, and was located above the interureteric ridge in the midline. It was estimated that the diverticulum would hold approximately 400 cc. of urine.

Dr. Joseph Sherrick: The diverticulum was huge, measuring 9 cm. in diameter, and grossly

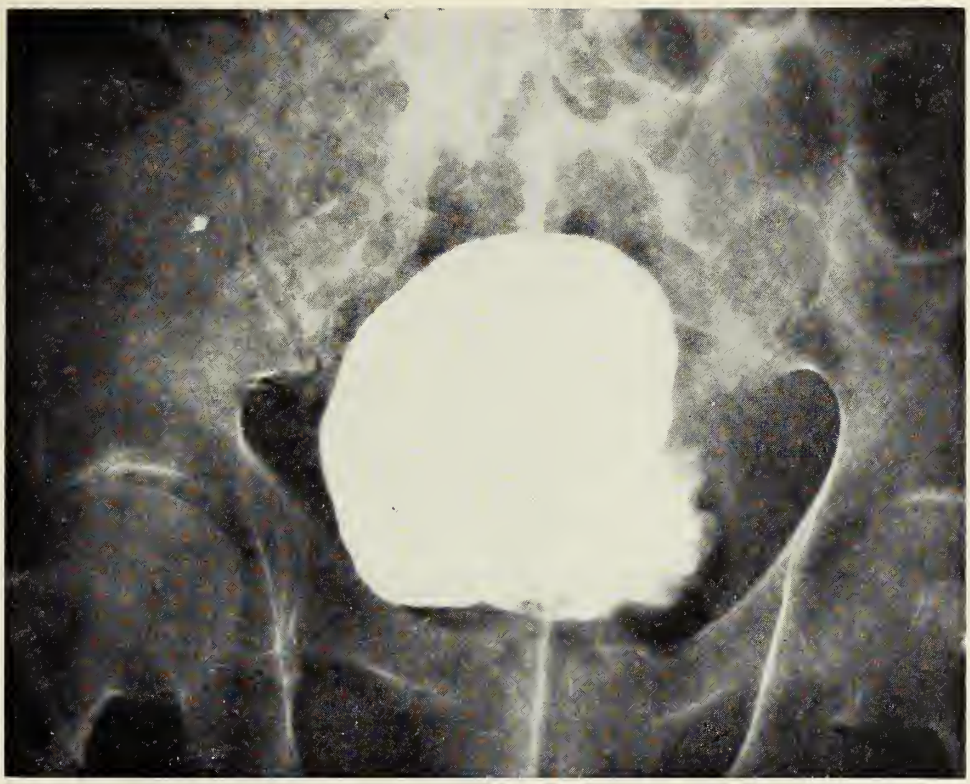


Fig. 1. The anterior view of the cystogram does not demonstrate the extent of the diverticulum.



Fig. 2. The lateral projection demonstrates a large diverticulum of the bladder.

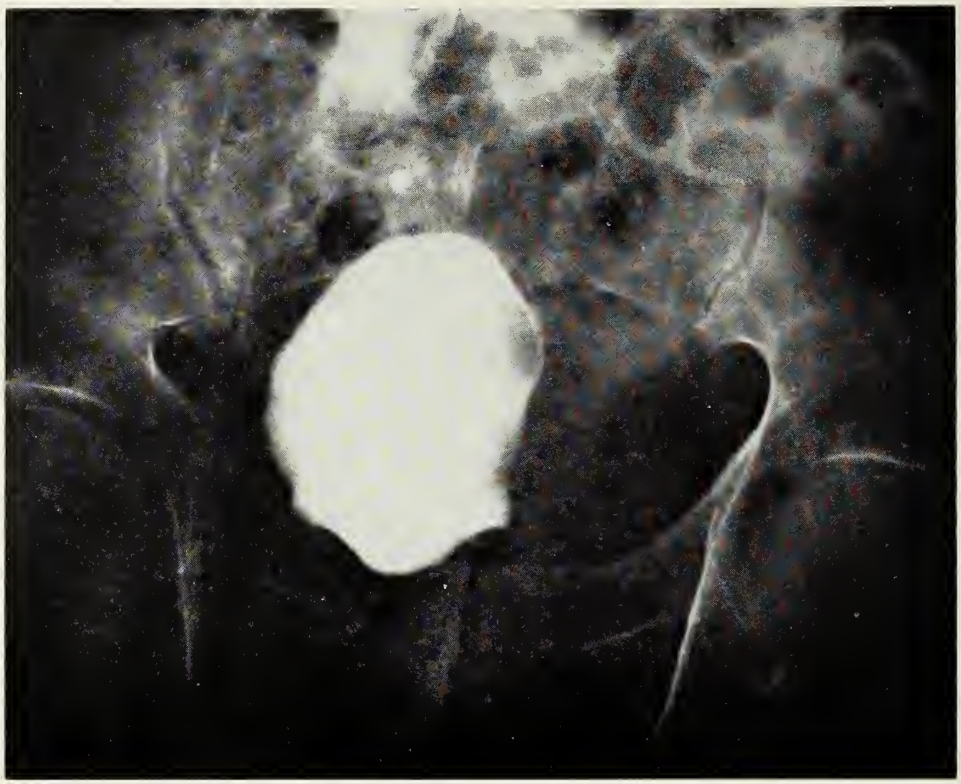


Fig. 3. After voiding, the cystogram demonstrates that the diverticulum has emptied but considerable contrast material remains in the bladder.

resembled a urinary bladder. Microscopically, the lining consisted of columnar epithelium in a simple pattern with mucinous glands which strongly resembled a colon (Fig. 4). There was no transitional epithelium. The wall contained fibrosed smooth muscle. We also received a portion of bladder neck. Microscopic examination of this showed a surface epithelium of the type that is seen in the urinary bladder. There were a number of little outpocketings or cysts in the epithelium. Some were lined by squamous epithelium, and others by transitional epithelium. Some of the outpocketings contained little mucus glands. These structures are normally present in the epithelium all the way up and down the urinary tract. Sometimes they can form mucinous glands of the type seen in Figure 5. Metaplasia of urothelium to a mucin-producing glandular epithelium can very well occur in the urinary bladder, where it is called cystitis glandularis or enteric metaplasia. This is a fairly rare condition that occurs in less than one per cent of specimens. Ordinarily, it is not associated with carcinoma, but we have had one case in which a huge stag horn calculus had led to glandular metaplasia, and ultimately to adenocarcinoma.

Dr. Hein: The first adequately documented case of bladder diverticulum was reported by Bartholin in 1520. At necropsy he found a diverticulum lying in the scrotum which contained a calculus. The most spectacular ever reported, in the 18th century, was an enormous diverticulum of the bladder which filled the entire abdominal cavity. The first vesical diverticulectomy was performed in 1895.

Bladder diverticula have been reported to occur in eight to 13% of patients with prostatic hyperplasia. This condition is found occasionally in women, sometimes without obstruction, but the great majority are found in men at an age when prostatism is prevalent.

The etiology of bladder diverticula remains obscure; both acquired and congenital factors are present. Of chief importance in the production of bladder diverticula is the role played by lower urinary tract obstruction. Urethral stricture, benign and malignant enlargement of the prostate, contracture of the vesical neck and median bar enlargement are the lesions responsible most often, although other lesions causing lower urinary tract obstruction have been implicated, especially in children.

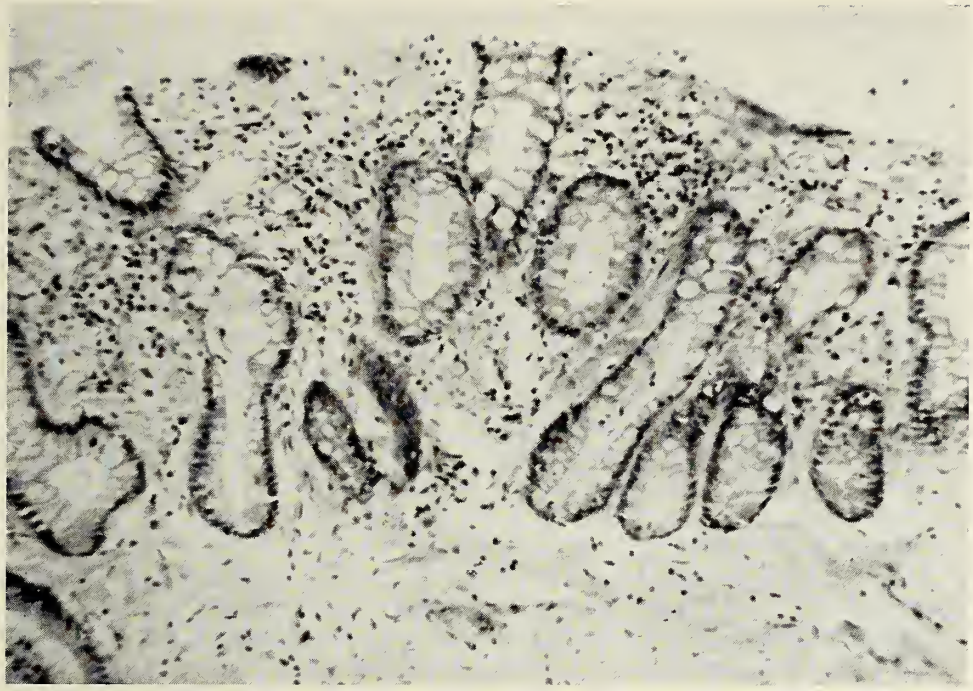


Fig. 4. The lining of the diverticulum consists of columnar epithelium which resembles colon.

The obstructed bladder, in attempting to empty itself, develops trabeculation, saccules and finally diverticula. Diverticula may be small or large, single or multiple, simple or multilocular. The wall of the sac consists largely of connective tissue and is deficient in muscular fibers. The sac is usually lined with vesical mucosa. Bladder diverticula may be asymptomatic. Often the patient, who harbors a bladder diverticulum, complains of symptoms caused by the bladder neck obstruction. Symptoms are often related to infection secondary to retained urine, such as frequency, dysuria, hematuria and pyuria. Other symptoms are slow stream, suprapubic pain, a

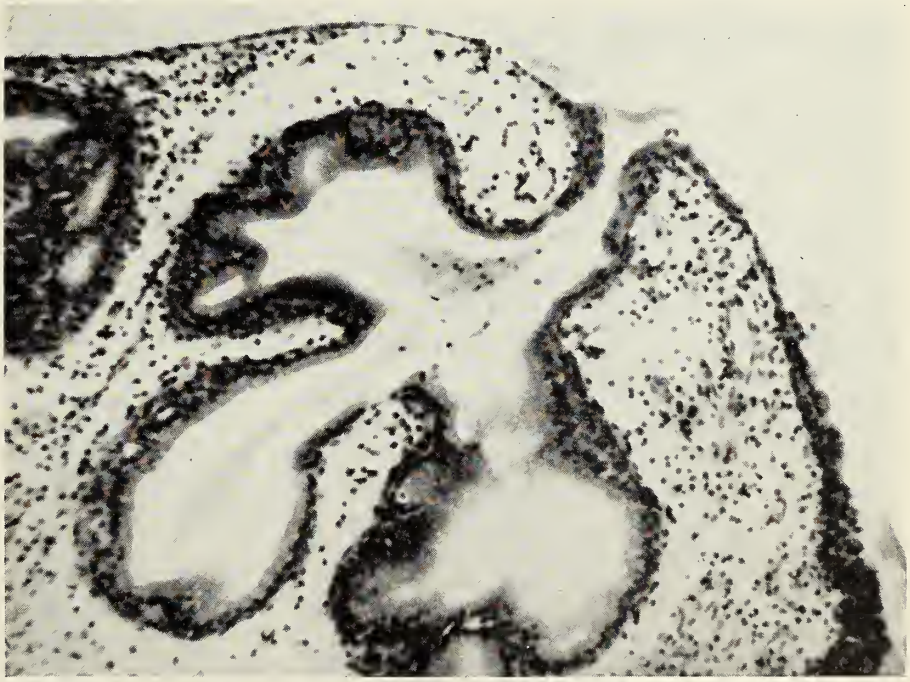


Fig. 5. Mucinous glands were found in the lining of the diverticulum.

sense of fullness in the lower abdomen and two stage micturition.

The diagnosis of bladder diverticulum is made by history, cystoscopy and cystography. Not only must the presence and size of the diverticulum be established but obstruction in the lower urinary tract and complications in the bladder and upper urinary tract must be sought.

There are four complications of bladder diverticula: infection, calculi, tumor formation and perforation. Infections are caused by urinary stasis within the diverticula. Pyuria is formed in approximately 44% and bacteriuria is found in 69%. Infection favors epithelial dysplasia and metaplasia, and in addition, causes technical difficulty at operation due to adhesions.

Stone formation is found in approximately five to 15% of the cases of bladder diverticulum. The classic triad of stasis, infection and stone formation applies as well to bladder diverticula as elsewhere in the urinary tract. The incidence of tumor formation is higher in diverticula than it is in normal bladders. Both benign and malignant tumors have been found within the diverticula, although the malignant variety outnumber the benign 4 to 1. Malignant tumors tend to be rapidly invasive and are of the epidermoid type. Perforation of a bladder diverticulum is rare and occurs in less than three per cent. Perforation is a serious complication and may result in abscess formation, peritonitis, vesical diverticulorectal and diverticulovaginal fistulas.

The treatment of bladder diverticulum depends upon whether or not the diverticula are retentive. Nonretentive diverticula do not require surgical removal. However, correction of the lower urinary tract obstruction is indicated when present, and may be followed by a decrease in the size of the diverticulum. Moderate or large retentive diverticula should be removed surgically.

Dr. John Grayhack: There are a few points in this patient's case that deserve emphasis. The first is the advisability of evaluating the urinary tract of any male with urinary tract infection completely. This patient had a urinary tract infection intermittently for some years. Each of the physicians who saw him tended to minimize diagnostic efforts because of the residual neurologic deficit remaining after removal of a meningioma 26 years ago. Consequently, the large residual urine which was the basic cause of the repeated infections was recognized belatedly. Secondly, the X-ray was misinterpreted by everyone except Dr. Cannon. It's easy to tell the diverticulum from the bladder if you know what the pathology of the lesion is. The diverticulum is an amuscular hollow viscus and the bladder has muscle around it. So the irregular structure is the bladder with its hypertrophied musculature; the smooth walled structure is the diverticulum. Lastly, the metaplasia seen in the diverticulum should have been suspected on the basis of the mucus found in the urine but it was not. A mucus forming gland should be considered a premalignant lesion. In most instances in which they are common in the bladder, such as extrophy, adenocarcinoma of the bladder is a common lesion. The poor prognosis associated with adenocarcinoma of the bladder is well recognized.

In treating this diverticulum, we could have gotten into the rectum because this is primarily a posterior lesion, lying just ventral to the rectum. The ureters are on either side and the pouch of Douglas is behind it. This is a relatively inaccessible area which may be approached in a variety of ways. Some of you undoubtedly still belong to the school that opens the bladder, puts in a sucker and gives one big tug. Whatever comes out you take off. That develops a lot of interesting lesions. Ordinarily, we would approach a diverticulum extravesically. This is usually safe, but occasionally is a difficult dissection because of adhesions between the diverticulum and adjacent structures. The other approach to a posterior diverticulum is transvesically. If you remember that this is an amuscular structure, once you incise the mucosa at the mouth of the diverticulum, you expose the exterior surface of the diverticulum. This can be dissected cautiously through the posterior bladder wall incision. If you find that the diverticulum is adherent to what appears to be rectum or ureters, which you can identify by inserting catheters, you should know that you can leave transitional epithelium in the retroperitoneum with impunity unless there is a malignancy. The best thing to do under these circumstances rather than skeletonize the ureter, is to leave a segment of transitional epithelium in the retrovesical space. I think you would be loathe to do this in a patient such as we discussed today because of metaplastic changes in the epithelium.

Everybody considers the diagnosis of diverticulum when you have a big prostate and the diagnosis is rarely missed. Characteristically, however, patients with a normal-sized or slightly enlarged prostate on palpation are not consid-

ered likely to have a large residual urine or a diverticulum. Consequently, patients with bladder neck contracture or median bar obstruction often have unrecognized bladder neck obstruction, allowing development of advanced changes such as those demonstrated today. ◄

Doctors and hospitals must report child abuse: Recent Supreme Court ruling doesn't invalidate state law

A recent ruling of the Illinois Supreme Court in no way invalidates the state law which requires doctors and hospitals to report suspected cases of physical abuse of children, said Edward T. Weaver, director of the Department of Children and Family Services, in a recent statement.

Weaver said the Supreme Court ruling dealt with another law passed almost a hundred years ago.

The law which requires medical personnel to report suspected child abuse cases to the Department of Children and Family Services—and is commonly referred to as the State Child Abuse Law—was passed in 1965.

Weaver said the 1965 law was based on model legislation proposed by the federal government and drafted in Illinois by a committee of legal and medical experts. All constitutional issues were reviewed thoroughly prior to the law's enactment, he added.

The director said he wanted to make sure that doctors and hospital personnel did not gain the impression that the Supreme Court ruling in any way lessens their legal responsibility to report cases of suspected child abuse to the Department of Children and Family Services.

"Some early news reports suggested that the court's ruling was related to the child abuse reporting law," Weaver said. "If this misinterpretation were to cause doctors and hospital staffs to stop reporting cases of suspected child abuse, it would be a tragic blow to the state's program for safeguarding the physical well-being of its children."

The Supreme Court ruling reversed the conviction and six month jail sentence of a Rockford man who had been found guilty of endangering the life of a child after a jury trial in the circuit court of Winnebago County.

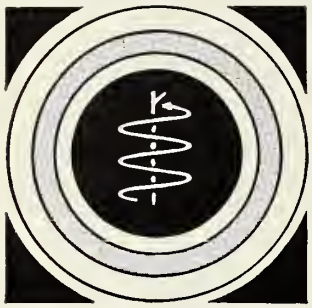
The conviction had been obtained on the basis that the man had violated provisions of a section relating to "offenses involving children" contained in the chapter of the statutes relating to charities and public welfare.

The court upheld the man's appeal that the section of the statutes under which he had been prosecuted failed to define "child" properly and was vague and indefinite in terms of the conduct it prohibited.

Weaver pointed out that there is no vagueness or ambiguity in the 1965 statute on child abuse.

He said the law specifically defines a child as "any person under 16 years of age," and emphasized that the other provisions of the law—all of which remain in effect—are equally specific. They require physicians and hospitals to report to the Department of Children and Family Services all suspected cases of child abuse within 24 hours of the examination of the child. The law gives specified medical personnel who file reports immunity from civil or criminal prosecution.

Weaver said the Department of Children and Family Services is investigating about 700 cases of suspected child abuse each year. The agency is required to afford protection to the child and other youngsters in the family when necessary and to provide social services aimed at rehabilitation of the family.



medical progress

The development of methemoglobin In mothers and newborn infants From nitrate in water supplies

By Abraham Gelperin, M.D., Eveline E. Jacobs, M.A., and Lucy S. Kletke, M.A./Chicago

Limit setting is fundamental for government as well as interpersonal relationships. The 1962 United States Public Health Service publication entitled *Drinking Water Standards* and the suggested limitations therein, in particular a maximum of 45 ppm of nitrate, has been widely adopted by States.[1] This recommendation in Illinois has created problems concerning practical management and restrictions in the use of major surface water supplies from reservoirs that are reaching or exceeding the recommended maximum during the spring runoff. Two municipal water supplies utilizing deep drilled wells and a considerable number of private farm wells throughout the State have had "excessive" nitrate concentrations for years.[2] This situation is extensive enough to have been a major subject of discussion at the Eleventh and Twelfth Sanitary Engineering Conferences conducted by the Department of Civil Engineering of the University of Illinois during February, 1969, and 1970.[3,4]

The reason for standards concerning nitrate concentration is the possible, though rare, development of methemoglobinemia in young infants, if the infant's intestinal flora converts the nitrate to nitrite and no further. It is the nitrite ion that combines with hemoglobin in preference to oxygen, especially with the hemoglobin F (fetal) as suggested by Kravitz, et. al.[5] and Metcalf.[6] Reviews of the literature concerned with the total subject reveal that many of the early reports which started in 1945, in the United States, did not consider either food intake, or that water analyses were made weeks after the diagnosis of methemoglobinemia. There were reports of only a rare case where nitrate concentrations were considerably above the maximum, and even when nitrate concentrations were quite low.[7,8] Recently, an inheritable methemoglobinemia has been described.[9] One study demonstrated subclinical methemoglobinemia in infants and children in the presence of appreciable nitrate concentrations.[10]

Veterinarians have also studied this problem for decades as it affects cattle, sheep, hogs and goats. Farm animals' water supplies, especially

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ponds that have accumulated surface water runoff from adjacent fertilized fields and animal excreta, can have marked nitrate excess. Animals drinking this water may develop severe methemoglobinemia, Vitamin A deficiency or diffuse hyperplasia of the thyroid. They may become infertile, suffer excessive fetal abortions, or die.[11-13]

The present study was initiated July 1, 1969, in order to investigate the possible relationships of high nitrate concentration in water supplies of one Illinois area and the development of methemoglobin in newborns and their mothers. The plan involved testing newborn infants and their mothers during their hospital stay, collecting data concerning their water supplies, and any medication intake of the mother. The Danville area became available through the cooperation of its physicians, the Division of Laboratories of the Illinois Department of Public Health for testing water samples, and the Lakeview Memorial Hospital and its pathologist, Dr. Grover Seitzinger.

Women who delivered in the hospital during the last week of April through June, 1970, are in this study. Blood specimens were collected twice a day and methemoglobin determinations were made (with one exception) not more than 11 hours later. All determinations were made by the same technician.[14] For those mothers having private well water supplies, a mailing container was given with instructions to mail a sample of the water to the State laboratory.

The Danville city water reached 45 ppm nitrate (10.3 mgN/litre) during the period April 26, to May 9. There was a drop to 37 ppm nitrate the following week, and from 32 ppm nitrate to 28 ppm from May 17, to June 28. A total of 137 mothers and infants were tested, including 72 Danville mothers and their newborns, and 65 pairs living outside of the area served by the Danville city water system. During July, 13 Danville mothers and their infants who had methemoglobin and eight non-city dwellers were retested. Unfortunately, the majority of those not living in Danville did not have well water tests, since not all samples were received by the State laboratory.

Therefore, data on Danville residents only, are evaluated. During the two weeks of maximum nitrate concentration, 10 mothers and 12 newborns had methemoglobin. The hospital routine of medication for delivery contained no known methemoglobin-producing drugs, and bottle water was supplied routinely to both mothers and newborns. The maximum concentration in a mother was 6.39%, and 5.87% in a newborn. Three mothers, who were found to be positive for methemoglobin, had infants who were negative. In five instances only the infants had methemoglobin, with seven occurrences of methemoglobin in both. The average was 1.18% for mothers and 1.91% in newborns.

During the third week, seven mothers and only one newborn out of 11 tested had methemoglobin. The average level dropped markedly, to 0.56% for mothers and 0.09% for newborns. The maximum levels also declined to 1.26% for one mother, and 1.07% for the one infant. During the next six weeks of continuing decline in nitrate concentration in the water supply, 29 mothers and five newborns out of 45 tested had methemoglobin. The average percentages were 0.77 for mothers and 0.06 for the infants.

Well water nitrate values were available on 21 non-Danville mothers and newborns. Only two had concentrations of 30 ppm in their well water supplies with the remainder, excepting



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EVELINE E. JACOBS, M.A., (center) is a research associate in the Department of Preventive Medicine and Community Health of the University of Illinois at the Medical Center.

LUCY S. KLETKE, M.A., (right) is also a research associate in the Department of Preventive Medicine and Community Health.

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three, having nitrate determinations under 10 ppm. The three exceptions had testings of 84 ppm, 88 ppm and 106 ppm nitrate. Yet two of these three mothers had 2.45% and 3.1% respectively, and one newborn 0.31% methemoglobin.

During July, of the 13 Danville mothers and their infants retested, four mothers still had traces of methemoglobin, and only one infant had methemoglobin (2.06%). Of the total of 22 pairs retested two to three months post partum, one infant was breast fed, 20 were on an identical prepared liquid formula, and the one infant with methemoglobin was on 2% skim milk and boiled city water. No mothers or newborns showed any evidence of clinical methemoglobinemia, or any abnormality during the three-day hospital period, or post hospitalization that could in any way be associated with these levels of methemoglobin.

Nitrate per se, in the concentrations found in the drinking water, must be converted by intestinal bacteria to nitrite. The nitrification-denitrification cycle is markedly variable in people at any one given period, and is also subject to modification in time.

Two observations become evident from this preliminary study. The first is concerned with the predominance of hemoglobin F in newborns and young infants. Methemoglobin in a newborn must be developed by either leakage of maternal blood through the placenta or diffusion of the nitrite ion from the mother's adult hemoglobin to the more susceptible infant's hemoglobin F. Explanation of how the event occurs requires further study.

The second observation tends to confirm, at least with this preliminary study, that the suggested maximum level of 45 ppm nitrate in drinking water may have some merit. The substantial drop in the levels of methemoglobin in newborns when the nitrate concentration in the Danville water supply dropped below 45 ppm suggests a mass effect, as in the study mentioned above.[10] However, the justification of the present maximum allowable level in water supplies is acknowledged to ignore the high concentrations in many foods[8] as well as that imponderable, the required conversion of nitrate to nitrite and all of the variables inherent therein.

The sources of nitrates in surface water supplies are many: polluted waters that have undergone self-purification; drainage from animal feed lots; fertilized farm land; and base flow of groundwater to streams during periods of low rainfall. Significant quantities of nitrogenous products are found in rainwater. Adequately treated domestic sewage is calculated to provide approximately 0.11 pounds of nitrate per person per day.[4,15] In addition, surface pollution sources such as putrescible "refuse," and excreta of city birds and animals add their quota.

The possible long-term effect of subclinical methemoglobinemia is unknown. Data were obtained on the numbers of children in special education during 1969, and registered in facilities of the Mental Retardation section of the State Department of Mental Health for five counties which have nitrate concentrations of the major surface water supplies around 45 ppm during the spring months, and five reasonably comparable counties with consistently low nitrate levels.[16] The five counties with high levels are LaSalle, Logan, McLean, Macon and Vermilion; the low-nitrate counties are Jackson, Madison, Rock Island, St. Clair and Williamson. No significant differences were found in this crude comparison.

Data were also obtained on infant mortality and cancer deaths for the 10 counties for the years, 1959-1968, from the Illinois Department of Public Health. These are in the process of analysis as to age, sex and race by disease categories. A thesis that nitrosamines may be involved in the development of cancer from the combination of nitrates or nitrites with degraded proteinous material has been suggested.[17]

This investigation does not answer the question of the validity of the present regulation of a maximum allowable nitrate concentration of 45 ppm in drinking water promulgated to prevent methemoglobinemia in young infants. Not unexpectedly, it has raised further questions with respect to suggested limitations when the sources of nitrate are multiple, concentrations of nitrate are variable, and mothers and infants may or may not convert nitrate to nitrite. Perhaps the serious problem relates to farm animals. Certainly the experience reported above[10] points to the necessity of continual monitoring of surface water supplies and their sources of pollution, as well as periodic evaluation of private water supplies. Although the treatment of methemoglobinemia, when instituted, is rapid and effective, the condition remains a potential threat to infants ingesting water from high-nitrate public or private water supplies. ◄

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(Continued on page 82)

New advances In the treatment of Human anovulatory infertility

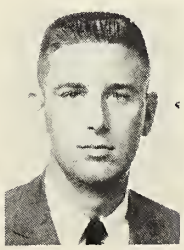
By Charles B. Hammond, M.D./North Carolina

Carl Hartman has described ovulation as the *sine qua non* of female reproductivity and certainly the extrusion of the mature Graafian follicle, ready for fertilization, must remain the central event in female fertility. In this paper I hope to review our understanding of the ovulatory process, discuss some of the causes of its failure, and finally present some details of newer methods of therapy.

Dependence of ovarian follicles upon anterior pituitary hormones has long been established—first in rodents by removal of the pituitary and then observing the response of the gonad to pituitary replacement therapy. These studies were extended to other animals, including primates, and revealed that follicular development could be induced in either the adult or the immature female by a variety of crude or purified pituitary extracts. Even heterologous species extracts frequently yielded responsiveness. Though ovulation can be induced in a variety of animals with some degree of dependability, we still do not entirely understand the chain of reactions which occur and have difficulty in describing the natural history let alone the physical and biochemical changes occurring at the subcellular level. Suffice it to say, ovulation does occur in the human. Let us now try to discuss some of the data that are known about this process.

Role of the Hypothalamus

Nearly 35 years ago, Hohlweg and Junkmann postulated the existence of a sexual center in the hypothalamus. Today there is little doubt that many of the sexual, as well as non-sexual functions of the adenohypophysis are under control of the central nervous system through the mediation of the hypothalamus and the special neurovascular linkage afforded by the hypophysial portal veins. While we cannot pursue the details of these mechanisms, many studies utilizing electrical stimuli, hormonal implants and stereotaxic techniques all document the ability of the pre-optic region and the median eminence



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to produce a humoral substance capable of regulating the anterior pituitary gonadotropin production. If indeed the hypothalamus controls pituitary function then what factors control the hypothalamus itself?

It is well known now that steroid hormones have the property of altering hypothalamic control of pituitary function. Certain progestins, notably the 17-nortestosterone derivatives, do have a suppressive effect on gonadotropins, but progesterone in the absence of estrogen is not a potent inhibitor of gonadotropin production nor does it lower the hypergonadotropuria in castrated or post-menopausal women. This is particularly true of the "mini-dosage" progestins. Small, acute doses of estrogen are accompanied by a fall of pituitary LH and a rise of plasma LH. Larger doses of estrogen inhibit gonadotropin secretion. Multiple implantational studies confirm these systemic observations. Experimental data by Sawyer and others indicate that the ovarian steroids act directly on certain elements within the hypothalamus and strongly influence the release of the anterior pituitary hormones. More recently, investigative data from patients treated with Clomiphene citrate—a non-estrogenic steroidial ovulation inducing agent—show rise in plasma LH and a reduction of pituitary LH.

There are a variety of pathologic processes which influence the hypothalamic regulation of pituitary gonadotropin secretion. These include space occupying lesions as neoplasms, cysts, and granulomas. The production of humoral substances from endocrinologically active tumors may also influence this system. Finally, major psychoses and neuroses can alter the hypothalamus' function (to the degree of anorexia nervosa), and minor emotional disturbances can inhibit the normal ovulatory response by the alteration of gonadotropin release.

Role of Anterior Pituitary

The pituitary gonadotropins include the follicle stimulating hormone (FSH) and luteinizing hormone (LH or ICSH). These are glycoproteins of large molecular weight of approximately 30,000 and are produced by certain types of the basophilic cells of the anterior pituitary. There has been controversy as to whether these gonadotropins really represent one moiety acting on different end organ receptors; now it is generally accepted that FSH and LH are separate entities. By means of colorimetric and chromatographic methods, Gröschel recently determined the carbohydrate components in human and ovine gonadotropins, which are both known to be glycoproteins. Galactose and mannose are present in differing ratios in the FSH and LH components. Such humoral agents as the gonadotropins may be measured by biologic, immunologic and radioimmunologic assay techniques.

Several investigators have reported that gonadotropins are not detectable by bio-assay in the urine of prepubertal children. Johnson stated that the presence of measurable gonadotropins in this age group is abnormal. Other laboratories, however, indicate that gonadotropins could be found in measurable quantities prior to puberty.

The prepubertal pituitary gland has been shown to be capable of stimulating the immature gonad in a number of different laboratory animals. There is also evidence for activity of the gonads and for their responsiveness to tropic stimulation in humans. Kulin's recent study showed biologically detectable gonadotropins (>10 muu) in 1/6 of the 459 24-hour urine specimens obtained from 44 normal children between four and 10 years of age. Seventy-five percent of the 44 children had at least one 24-hour urine that yielded a positive result. Other data from that same study demonstrates the frequency of finding gonadotropins in the prepubertal child increased with age.

This finding complements the observations of Fitschen and Cloyton who showed that the marked rise in gonadotropin excretion toward adult values occurs well into puberty. The earliest developments of secondary sexual characteristics, then, appear to be associated with small, if any, increases in total gonadotropin excretion.

By means of a radioimmunoassay, Bagshawe detected smaller amounts of LH in the urine of children than in adult males. Odel, et al., however, also using a radioimmunoassay, found serum LH levels closely approximating the LH values found in adults, but without the midcycle type surge in LH excretion. These discrepancies may perhaps be explained by variation in sensitivity of assays and differences in the renal clearance of gonadotropins in adults and children.

The relationships of FSH and LH to estrogen and progesterone have been vigorously studied since Hisaw's classic paper in 1947. Data suggests that both FSH and LH are present throughout the menstrual cycle but at mid-cycle there are

increases in both. During the luteal phase there is a decline of both gonadotropins, followed by a rise in excretion toward the end of the luteal phase that continues into menstruation.

Both FSH and LH are secreted throughout the menstrual cycle. FSH is thought to be responsible for the growth and development of the ovarian follicle. Early in the cycle, as the primordial ovarian follicle migrates from beneath the tunica albuginea, the granulosa cells surrounding the ovum proliferate and a crescenteric cavity is formed by liquefaction of a portion of the granulosa cells. Fluid accumulation in this cavity slowly distends the follicle. The connective tissue surrounding the follicle becomes differentiated into the theca interna and becomes rich in epithelial cells that are thought to be the main source of estrogen. The development of the follicle up to the antrum stage is independent of FSH, but its further growth is dependent upon FSH. The cells of the theca interna produce increasing amounts of estrogen, which is generally regarded as diminishing the production of FSH.

Luteinizing hormone is generally regarded as the hormone responsible for ovulation. Without LH, the follicle stimulating hormone can produce follicular growth but estrogen production is limited. Just prior to midcycle there is an increased secretion of LH, and rupture of the ovarian follicle and ovulation.

In all of these, the only consistent findings are the presence (in measurable amounts) of both gonadotropins and the presence of an increased amount of both at approximately midcycle.

From all of these techniques one can begin to determine the timing, ratios and amounts of the gonadotropins during the menstrual cycle. Certainly much more work must be done to fully clarify these processes.

There is a definite and rapid hypergonadotropism following castration of responsive gonads or premature and normally timed menopause. These levels may more than treble the cycling range values of total gonadotropins and appear primarily to be due to an increase production of FSH. After three to five years this relative hypergonadotropism slowly subsides to eventually fall into normal to reduced ranges.

Other pathologic states are associated with similar hypergonadotropism—such as gonadal agenesis. Eugonadotropism is more frequently seen in the polycystic ovary syndrome, anorexia nervosa, general debilitating diseases and the so called "hypothalamic block" problem.

From these bits of data one can identify a variety of disease entities capable of influencing the release and ratio of pituitary gonadotropins. Some of these are space occupying pituitary lesions (cysts, granulomas and neoplasms), Sheehan's syndrome of post-partum pituitary necrosis, Simmond's disease (panthypopituitarism), acromegaly, and isolated gonadotropin deficiencies.

Role of the Ovary

The human ovary at birth shows a cortex tightly packed with primordial follicles, and almost no interstitial tissue. Estimates are that there are approximately 500,000 in these newborn ovaries from the somewhat meager evidence such as the finding of a Swedish investigator who counted 420,000 eggs in the ovaries of a 22-year-old girl. In the human, as in other mammals, generally none are left after the age of sixty. If one ovulation was achieved with regularity every month of life from the age of 12 through 50, less than 500 eggs of such a girl would ever achieve ovulation. By far the vast proportion, therefore, are lost in the process of atresia which begins at birth and continues through to menopause.

Sturgis has suggested that the interplay between pituitary gonadotropins at the time of ovulation not only insures that one follicle achieves maturation, but also may precipitate dissolution of the next largest follicles in both ovaries at that time. The institution of atresia might well be due to the action of LH on these "second rank" follicles that are immature and unable to withstand such stimulation. It is at the midcycle peak of LH effect that these follicles show dissolution of granulosa cells and hypertrophy of the theca interna.

A striking example of this is sometimes seen in the neonatal ovary where theca luteinization of immature follicles occurs, presumably in response to the LH effect of circulating maternal gonadotropins. Another example of theca proliferation of immature follicles associated with fluctuating LH peaks is also found in the polycystic ovary syndrome. The theca activity of such follicles that are destroyed lasts only several days but it is highly probable that this tissue produces steroids during the transient phase of its existence. Since estrogens are of prime importance at this critical time in the cycle to

Human anovulatory infertility

stimulate optimal cervical secretions, tubal peristalsis, and endometrial proliferation, it seems a likely guess that this theca thickening helps maintain the circulating level of estrogens.

Because of its vesicular appearance, the follicle has been regarded as similar to a "blister which burst open." It was initially thought that internal pressure in the follicle became to great to be retained by the follicle membrane. This has been negated by studies which failed to show any increase in intrafollicular pressure prior to or at ovulation. In clinical observations in man and animals it has been noted that follicles may grow far beyond the size normally seen in ovulatory cycles and these excessive sized cysts have even greater pressures without rupture.

It would appear that ovulation mechanisms must logically concentrate within the region of the maculua pellucida or stigma. It is believed that the cumulus oophorus is loosened from the stratum granulosum and that the ovarian follicle ruptures in response to the action of LH. LH appears to have a "triggering" effect on preovulatory follicles, which runs its course until ovulation occurs.

Investigators have been impressed with the orderly sequence of events in the formation of the stigma in ovulatory follicles. The actual edges of the rupture site are seldom torn or irregular, thereby suggesting a biochemical type of membrane dissolution. Unfortunately, neither cytologic or fine-structural studies have yet been carried out on these tissues.

Again, from this brief discussion we can anticipate a number of disease entities capable of rendering the ovary unresponsive to gonadotropins and thus causing anovulatory infertility. Some of these include agenesis or dysgenesis, premature ovarian failure, surgical removal and normally timed ovarian failure (menopause).

Figure 1 summarizes our methods for the evaluation of the anovulatory patient, including those studies necessary if infertility is also a problem. The most important factor is to diagnose central nervous system neoplasia, the primary threat to life and vision. Even if routine studies such as skull films, visual fields and measures of tropic end-organ function are initially all normal, these patients must have regular and repeated follow-up. Many studies document that anovulation (amenorrhea) may precede clinically diagnosable CNS tumors by intervals of many years. One next evaluates the patient for the correctable causes of anovulation (hypothyroidism, Cushing's Syndrome, etc.) and the incorrectable causes (ovarian dysgenesis, premature ovarian failure, etc). For these two categories of patients ovulation induction is offered to the former group desiring fertility and replacement therapy with estrogen and progesterone is offered the others.

Anovulation

Pre-Treatment Evaluation

General history, physical and pelvic examination of husband and wife, greater than six months documentation anovulation (Amenorrhea; monophasic BBT; non-secretory endometrial biopsies).
Thyroid: PBI, T_3Uptake, T_4, I_{131} Uptake.
Adrenal: 17 OH, 17 KS, plasma testosterone, Pregnanetriol, (Possible ACTH, SU4885, Dacadron testing).
Pituitary: Skull films, visual fields, gonadotropins.
Ovarian: Progesterone withdrawal, buccal smear, vaginal cytology, culdoscopy/laparoscopy.
Hysterosalpingogram.
Husband's seminalysis.

Fig. 1

Ovulation Induction

There are several methods currently available to induce ovulation in anovulatory women. These go back to the laboratory animal injection of yeast extracts, copper salts and cadmium. In humans, the injection of estrogens, human chorionic gonadotropin and the ingestion of estrogen-progesterone, thyroid and cortisone—all have been listed as having limited success in ovulation induction. Hamblen reported limited success by the sequential injection of heterologous gonadotropins (PMS and HCG).

Tyler reported moderate (33%) success in anovulatory women by inducing ovulation with a nonsteroid agent known as MER-25. Toxicity, however, was prohibitive. In 1960, a new nonsteroid agent, structurally related to chlorotrianisene (TACE) became available as Clomiphene citrate (Clomid). While in animals this compound had antifecundity properties, it has now been shown to produce ovulation in up to 75% of anovulatory, well-estrogenized women. It is thought to be antiestrogenic, luteotropic and to function primarily by action in the hypothalamus, yielding release of endogenous pituitary gonadotropin (LH primarily). Because it is oral, relatively inexpensive, and has a fairly good margin of safety, it would appear to be the best

agent to begin therapy for anovulatory infertility. A variety of dosage schedules has been worked out using either Clomid alone or in combination with HCG.

Human gonadotropins have also been used successfully for human ovulation induction since Gemzell's work in 1960. Originally pituitary sources were used to extract both FSH and LH and were successful when sequentially administered to anovulatory women with responsive ovaries. Daily FSH injections were given until evidences of estrogen production showed tangientially that follicular and para follicular systems were stimulated, then LH as a "surge" for release of the mature follicle). Due to expense, however, later studies have utilized human urinary FSH and human chorionic gonadotropin. While very successful in inducing ovulation the problems of multiple gestations and massive ovarian cystic enlargements continue to present problems in the safe use of such agents. Many authors present adequate studies to prove the success of these agents for ovulation induction in essentially 100% of anovulatory women treated. Safety, however, continues to be a problem.

In 1969, we presented the results of 29 patients who received human gonadotropins (urinary FSH and HCG), given in a sequential manner with gradually increasing dosages of FSH in consecutive cycles until the "minimal ovulatory dose" was obtained for each patient. These data are listed in Figure 2, and document the effectiveness of such agents for both ovulation and fertility. There was one multiple pregnancy, twins, at a higher dosage than had previously been used to induce an ovulatory (but non-conceptive) cycle and the incidence of cystic ovarian enlargement was quite minimal. No severe adverse effects occurred. These data seem to support the theory that all of the side-effects are "dose related" and safe, effective treatment regimens await better delineation of individual dosage schedules.

Ovulation Induction with Human Gonadotropins
Response by Diagnostic Category

Ovulatory Status	Ovarian Status	Total no. patients	No. pts. ovulating	Mean FOD*	No. pts. Conceiving
Oligo-ovul.**	sclerocystic	5	5	9.6	2
Oligo-ovul.	normal	9	9	14.7	4
Scdy. anovul.†	normal	4	4	18	3
Scdy. anovul. & lactation	normal	6	6	28.2	2
Scdy. anovul.	sclerocystic	3	3	34	1
Primary amenorrhea	normal	2	2	22.5	1
Totals		29	29		13

*FOD—first ovulatory dosage, in ampules of Pergonal (75 IU FSH/ampule) HCG dosage of 10,000 I.U.

**oligo-ovulation—infrequent ovulation not more often than x2/year.

†anovulation—absent ovulation for more than one year.

Fig. 2

Summary

This paper has attempted to review our knowledge of the ovulatory process, our methods of evaluating such anovulatory patients and some of the newer methods of inducing ovulation for those patients who desire fertility. None of these techniques are perfect, reflecting the major areas of limited knowledge of human reproduction. However, we can now offer techniques to better diagnose and treat human anovulatory infertility, a problem which has beset physicians for years. ◄

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(Continued on page 74)

The "nose drop nose" Due to Oxymetazoline (Afrin) and Other topical vasoconstrictors

By Alan R. Feinberg, M.D. and Samuel M. Feinberg, M.D./Evanston

Oxymetazoline hydrochloride (Afrin) is a recent nasal topical vasoconstrictor responsible for a large percentage of chronic nasal congestion due to rebound effect. Among the last 500 new patients of all types seen in a private allergy practice there were 46 who came to us with severe nasal obstructive symptoms whose major difficulty could be traced to topical vasoconstrictors. Of these, 22 were due to oxymetazoline while 24 were due to several other vasoconstrictors. Although substitution of oral decongestants or topical corticosteroids was effective in some instances, the most satisfactory treatment was a short course of oral steroid therapy. Specially designed studies are suggested for new topical vasoconstrictors before they can be judged to be free of rebound effect. Present products should be employed for very short term or emergency situations.

When a topical nasal decongestant is used, it produces its effect by vasoconstriction and consequent reduction of the localized edema. When the vasoconstrictive action disappears, there is always a compensatory vasodilatation with engorgement and swelling greater than before the decongestant has been used. Therefore, the sufferer again resorts to the use of the drops or spray. With each cycle the congestion increases. He uses the vasoconstrictor because it immediately corrects his complaint. He does not know that soon he has perpetuated the condition he is trying to alleviate. He now encounters the problem of rebound congestion.



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Samuel M. Feinberg, M.D., (right), is director of the Allergy Research Laboratory, Evanston Hospital, and maintains a private practice. He received his M.D. from Rush Medical College. Dr. Feinberg is a Fellow of the American College of Physicians, and a recipient of the American Academy of Allergy's Award for Meritorious Service. In addition, he has authored six books on allergy.



Most of the time neither the physician nor the patient recognizes that an adverse reaction from the medication has arisen which can only be corrected by the discontinuance of this type of medication. When it is recognized, it is apt to be classed as "rhinitis medicamentosa," implying a chemical irritation. In some instances and with some medications this may be the case because of the irritating nature of the preparation. However, the more important problem is the induction of a chronic state of nasal edema because of rebound effect.

The typical history of such a patient is as follows: A number of months ago he had a cold or moderate obstructive symptoms from nasal allergy. Topical nasal medication was either prescribed by the physician or purchased over the counter. Good relief resulted but the nasal stuffiness persisted and the need for more frequent use of the medication became more demanding. At this point oral antihistamines or oral decongestants, which may have given some relief in the past, no longer produce benefit. When the topical vasoconstrictor has not been used for several hours and the sufferer's nasal obstructive symptoms are more severe than they were before the use of the vasoconstrictor was begun, a "nose drop nose" should be suspected.

Twenty-five years ago we called attention to this rebound effect from the use of naphazoline hydrochloride.[2] There are several additional topical decongestants, among which are tetrahydrozoline hydrochloride, phenylephrine hydrochloride, propylhexedrine, xylometazoline hydrochloride and more recently oxymetazoline hydrochloride. With each drug, the hope existed that it would solve the rebound effect. With oxymetazoline the longer action and the more gradual wearing off of the vasoconstrictor effect were regarded as characteristics which would probably minimize the problem. Indeed the reports on the efficacy of the drug either ignore the potential of rebound effect or categorically state that it does not exist with this drug.[4-6] The Council on Drugs of the American Medical Association[1] did warn in 1965 "Like other intranasal medications, oxymetazoline may produce a rebound vasodilatation and chemical rhinitis with prolonged use." One paper[7] mentions the effective use of intranasal dexamethasone spray in severe nasal congestion due to "chemical rhinitis" from nose drops, in three out of the four cases after the use of oxymetazoline. Unfortunately the significance of this syndrome is missed when it is not identified as a rebound effect. The criticism of most of the studies of oxymetazoline as well as other nose drops or sprays is that they are designed to observe the effectiveness in duration and degree without paying sufficient attention to the increased state of intumescence induced when the use of the drug is temporarily stopped.

Shortly after oxymetazoline was introduced we became increasingly conscious of the fact that its use was producing a rebound chronic congestion. We have therefore attempted to analyze the size of the problem by examining the records of our new patients.

Method of Study

In an examination of the records of the last 500 new patients from our office practice we found 46 who came to us primarily for severe nasal obstruction, presumed to be allergy, whose major problem proved to be a rebound nasal congestion due to the use of vasoconstrictor nose drops or sprays. These could be divided into two groups: Group 1 (22 patients) owed their difficulty to oxymetazoline; while Group 2 (24 patients) include those who had their problem due to a variety of drugs—two to a solution of phenylephrine, thenyldiamine and benzalkonium, 16 to phenylephrine, one to xylometazoline, two to naphazoline, and three to other combinations. With both groups the sexes were about equal and most of them were in the 30 to 50 age group, although most other ages were represented. Marked nasal stuffiness was the outstanding complaint, with sneezing or rhinorrhea of lesser importance. Marked swelling of nasal turbinates was always present, the appearance being pale or red. Eosinophilia in the nasal smear was present less often than in the nasal patients without rebound effect. The majority had had this syndrome for over six months and 19 for more than a year. In Group 2, topical applications were used three to five times daily in 11, six to 10 times in nine, more than 11 times in one patient, while only three patients limited themselves to one or two daily applications. In Group 1, the applications were less frequent; three patients using them once daily, eight twice daily, and 11, three to five times. This suggests that oxymetazoline is longer acting than Group 2 as a whole. Allergy, as noted

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by significant skin test reactions, was present in 16 in Group 1 and 17 in Group 2.

Treatment

The first procedure in these cases, even before possible allergy was investigated, was to attempt to break the vicious cycle of rebound effect. Four patients were able to obtain improvement by simply discontinuing the topical medication, 14 were able to substitute oral for topical decongestants, 12 responded to dexamethasone spray, and 16 were given systemic corticosteroids. By these means 100% relief was obtained in nine patients. These nine obviously never had had allergy, or at least allergy was not a problem when they presented themselves to us. Twenty had 75% relief, 15 obtained 50% relief and two had only slight improvement.

The final disposition of the 46 patients was as follows: 20 were discharged, having either no symptoms or being controlled by moderate use of antihistamines; 20 are under allergic care, some of them receiving antihistamines or oral decongestants from time to time; three have failed to return for final observation; and three others must be considered failures in our attempts at breaking the rebound cycle.

The most effective method of breaking the rebound effect is the use of systemic corticosteroids. A corticosteroid spray is the second choice, but psychologically it may not be always wise to substitute one type of spray for another. Usually we prescribe prednisone to be taken orally three times daily, with a daily dosage of 30 mg. the first two days, and then gradually tapering off. A 10 day period is normally allowed for the course of treatment. Other corticosteroids can be used, of course. As a rule, by the second or third day the patient can discontinue his nose drops or spray.

Jarvis,[3] of Cape Town, South Africa, discussed the "nose drop addict" and recommends a course of oral steroids combined with oral antihistamines. He has also employed the injection of a slowly absorbing corticosteroid into the inferior concha of such patients.

We would propose that in the future all nasal decongestants be subjected to the following study. A group of normal individuals as well as those with chronic nasal allergy should be first observed visually and by airway studies with and without oral nasal decongestants. The topical medication should be used for days, weeks and months and interim evaluation of airways be made after skipping the topical application. At the same time the effectiveness of the oral decongestants should be examined periodically. Only if there is no increased congestion under these circumstances can a topical vasoconstrictor be claimed to be devoid of rebound effect. Until that time we should confine the use of all topical decongestants to special situations, such as for a sinus infection, a severe cold, or for short term use such as for altitude changes during flying, and with a warning to the patient that the medication must not be used for a period longer than two or three days.

Nonproprietary and Trade Names of Drugs

Naphazoline hydrochloride (Privine)
Oxymetazoline hydrochloride (Afrin)
Phenylephrine hydrochloride (Neosynephrine)
Propylhexedrine (Benzedrex)
Tetrahydrozoline hydrochloride (Tyzine)
Xylometazoline hydrochloride (Otrivin)
Dexamethasone sodium phosphate spray (Decadron Turbinaire)
Phenylephrine, thenyldiamine, benzalkonium (NTZ solution) ◄

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new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

Approval has been granted by the National Institutes of Health, Division of Biological Standards for the following new biologicals, not marketed as yet.

MEASLES AND RUBELLA VACCINE
MEASLES, RUBELLA AND MUMPS VACCINE
Manufacturer: Merck Sharp & Dohme

The following new drugs have been marketed:

NEW SINGLE CHEMICAL

URISPAS Urinary tract spasmolytic ℞
Manufacturer: Smith Kline & French
Nonproprietary name: Flavoxate HCl
Indications: Symptomatic relief of dysuria, urgency, nocturia, suprapubic pain, frequency and incontinence as may occur in urinary tract diseases
Contraindications: Obstructive conditions of the gastrointestinal and lower urinary tracts
Dosage: Adults and children over 12 years: 1 or 2 tablets 3 or 4 times a day
Supplied: Tablets, 100 mg.

DUPLICATE SINGLE PRODUCT

HUMAFAC Biological ℞
Manufacturer: Parke, Davis
Nonproprietary name: Antihemophilic factor (Human)
Indications: Classical hemophilla (hemophilia A)
Contraindications: None mentioned
Dosage: Individualized
Supplied: Vials 80, 125, 175 or 250 AHF units

NEW DOSAGE FORMS

CANDEPTIN
VAGELLETTES Antiinfectives-Vaginal ℞
Manufacturer: Schmid
Nonproprietary name: Candicidin
Indications: Vaginitis due to *Candida albicans* and other Candida species
Contraindications: Hypersensitivity to any of the components
Dosage: One capsule inserted high in the vagina, twice a day, morning and bedtime, for 14 days
Supplied: Vaginal capsules, 3 mg.

ISORDIL TEMBIDS
Capsules Vasodilators-Coronary ℞
Manufacturer: Ives
Nonproprietary name: Isosorbide dinitrate
Indications: Sustained prophylaxis against angina pectoris
Contraindications: Idosyncrasy to the drug
Dosage: One capsule every 6-12 hrs. according to need
Supplied: Sustained action capsules, 40 mg.

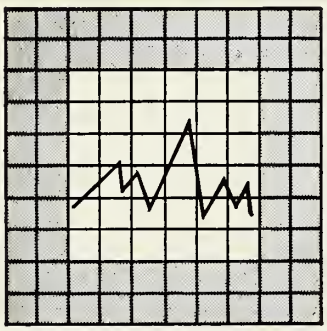
ISORDIL TEMBIDS
Tablets Vasodilators-Coronary ℞
Manufacturer: Ives
Nonproprietary name: Isosorbide dinitrate
Indications: Sustained prophylaxis against angina pectoris
Contraindications: Idiosyncrasy to the drug
Dosage: One tablet every 6-12 hrs. according to need
Supplied: Sustained action tablets, 40 mg.

VASODILAN Syrup Vasodilators-Peripheral ℞
Manufacturer: Mead Johnson
Nonproprietary name: Isoxsuprine HCl
Indications: Peripheral vascular disease
Contraindications: None mentioned
Dosage: 10 mg.
Supplied: Liquid, each tsp. contains 10 mg.

VERSAPEN-K
Intramuscular Penicillin & Derivatives ℞

Manufacturer: Bristol
Nonproprietary name: Hetacillin potassium 225 and 450 mg. ampicillin activity (with Lidocaine HC1) 20 and 40 mg.
Indications: Susceptible strains of bacteria
Contraindications: Hypersensitivity reactions to any of the penicillins or to lidocaine
Dosage: Mild to moderate infections:
Patients over 90 lbs.: 225 mg. q.i.d.
Patients under 90 lbs.: 2.5 mg./lb. q.i.d.
More severe infections:
Patients over 90 lbs.: 450 mg. q.i.d.
Patients under 90 lbs.: 5 mg./lb. q.i.d.
Supplied: Vials 225 and 450 mg.

VERSAPEN-K
Intravenous Penicillin & Derivatives R
Manufacturer: Bristol
Nonproprietary name: Hetacillin potassium
Indications: Susceptible strains of bacteria
Contraindications: Hypersensitivity reactions to any of the penicillins
Dosage: Mild to moderate infections:
Patients over 90 lbs.: 225 mg. q.i.d.
Patients under 90 lbs.: 2.5 mg./lb. q.i.d.
More severe infections:
Patients over 90 lbs.: 450 mg. q.i.d.
Patients under 90 lbs.: 5 mg./lb. q.i.d.
Supplied: Vials, 225 and 450 mg. ampicillin activity



ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D.
and Patrick Scanlon, M.D./Section of Cardiology,
Department of Medicine
Loyola University Stritch School of Medicine

The patient, a 62-year-old white male, was seen in the emergency room complaining of palpitation and dyspnea. Past history disclosed the patient to have had a myocardial infarction three years previously. The palpitation and dyspnea had been present two weeks, particularly with exertion. Physical examination disclosed a pulse of 75, BP 140/100, and slight neck vein distension at 45°. The PMI was in the 5th interspace 3 cm. left of MCL. S_1 was slightly decreased at PMI. S_2 was slightly accentuated at the sternal border and 3 LIC, especially the pulmonic component. An S_3 (ventricular gallop) sound was present at the PMI. Moist rales were audible at both lung bases and did not clear with cough. An arrhythmia was present, characterized by a premature contraction. A rhythm strip showing $V_{1\text{-}2\text{-}3}$ simultaneously recorded is seen. (See facing page.)

QUESTIONS (One or more of the following statements are correct):

1) The premature beat is of atrial origin.
2) The premature beat is of ventricular origin.
3) A remote transmural antero-septal infarction is demonstrated.
4) The patient has evidence of incipient left ventricular failure.
5) No evidence of previous myocardial infarction is seen.

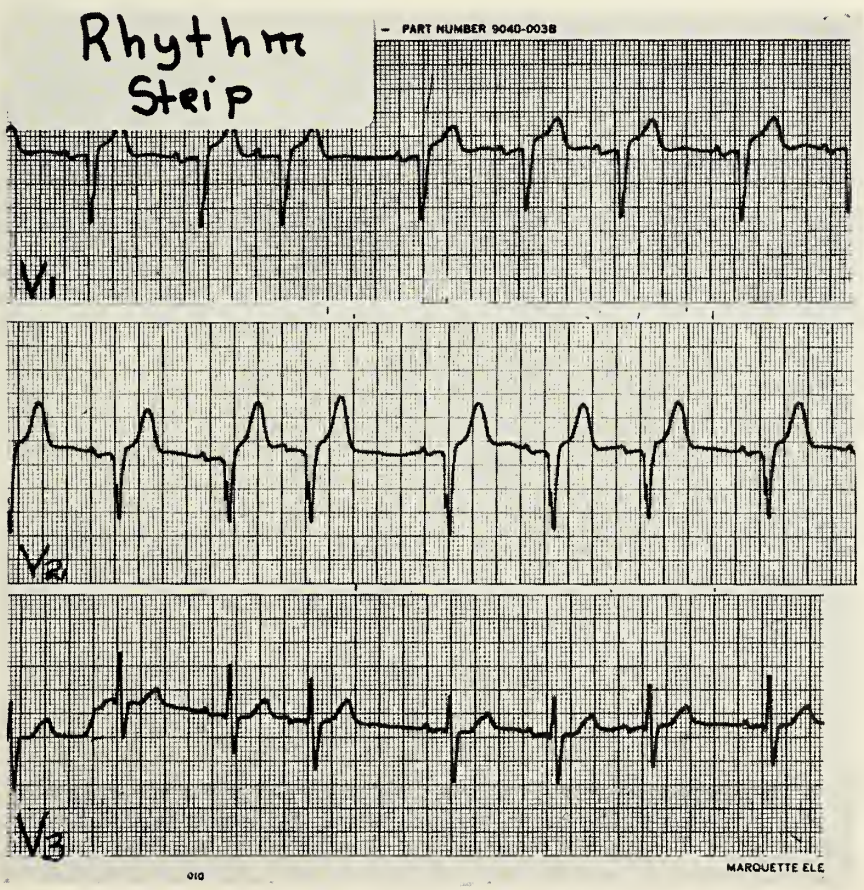
(Answers on page 79)

Guide on cardiac catheterization Sets safety diagnostic standards

A new booklet intended to assure patient and personnel safety in performing cardiac catheterization as well as to promote maximal diagnostic accuracy, obviate unnecessary procedures and minimize the need for repetition, has been published by the Heart Association.

Entitled "Standards for a Cardiac Catheterization Laboratory—A Guide for Cardiologists and for Institutions Sponsoring Cardiac Catheterization Laboratories," the report was prepared by the Association's Council on Rheumatic Fever and Congenital Heart Disease and Council on Clinical Cardiology. The first AHA statement of standards for catheterization laboratories, it covers personnel, equipment, radiation protection, procedures and case load.

Copies of the booklet may be obtained through local Heart groups or from the AHA National Office, 44 E. 23rd St., New York, N.Y. 10010.





the doctors library

Surgery of the Chest. By John H. Gibbon, Jr., David C. Sabiston, Jr., and Frank C. Spencer, 2nd Edition. Philadelphia, London, and Toronto: W. B. Saunders Co., 1969.

The second edition of SURGERY OF THE CHEST, edited by Gibbon, Sabiston and Spencer, further strengthens the position of this text as one of the leaders in the field of thoracic surgery. The original 32 chapters have been expanded to 42 with a commensurate increase in the number of contributors. Fifteen of the chapters have been revised and 27 are entirely new. Most of the latter cover the newer developments and increase in knowledge in the field of cardiac surgery.

The chapters are scholarly and well written. The illustrative material is excellent, although some of the reproductions of the chest roentgenograms are not as clear as one would like. The bibliographies are extensive and reasonably complete.

The chapters on Cardiorespiratory Dynamics, Congenital Lesions of the Lungs and Emphysema, Neoplasms of the Lungs and Trachea and most of the ones concerning the heart are outstanding. In contrast, several other chapters do not attain as high a level of excellence. The chapter on Radiologic Diagnosis is weak and the reviewer sees no real need to include a chapter on the Thoracic Autonomic Nervous System in a textbook for thoracic surgeons.

With these minor reservations, the volume may be highly recommended to the thoracic surgeon in practice or in training.

Thomas W. Shields, M.D.

The Doctor's Shorthand. By Frank Cole. W. B. Saunders Co., Philadelphia. 1st Ed., 179 pages, $4.50.

The physician graduating from medical school more than 20 years ago may be interested in this little book. During the past two decades, medical students and interns acquired a new set of hieroglyphics and abbreviations which they incorporate in case histories, progress reports and examinations.

Abbreviations save time and space but are useless unless the reader knows what they mean. SOB means short of breath and not what you may think it is. Kcal is kilocaloric. ND may mean neonatal death, neurotic depression, Newcastle disease, new drugs, no data, no disease, nondisabling, normal delivery, not detected, not determined, or not done. And VD are not the last initials of your editor. These stand for vapor density and venereal disease.

T. R. Van Dellen, M.D.

Hospital births boom!

More babies were born in hospitals in 1970 than in 1969, according to the American Hospital Association. And this is the second straight year that hospitals reported an increase in births. During the years 1962 through 1968 hospital births decreased each year after reaching their all-time high of 3,908,121 in 1961.

The births reported in 1970 totaled 3,537,000. In 1969 hospital births totaled 3,319,315.



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Summary of House Actions

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PRES-ELECT	Frank J. Jirka, Jr., 1507 Keystone, River Forest 60305
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2ND VICE-PRES	William Adams, 55 East Erie, Chicago 60611
SEC.-TREAS.	Jacob E. Reisch, 1129 S. 2nd, Springfield 62704

House of Delegates

SPEAKER OF THE HOUSE	Paul W. Sunderland, 214 N. Sangamon St., Gibson City 60936
VICE-SPEAKER	Andrew J. Brislen, 6060 S. Drexel, Chicago 60637

Trustees

1ST District	1974	Joseph L. Bordenave, 1665 South St., Geneva 60134
2ND District	1974	Allan L. Goslin, 712 N. Bloomington, Streator 61364
3RD District	1973	David S. Fox, 20829 Greenwood Center Ct., Olympia Fields 60461
	1973	Robert T. Fox, 2136 Robin Crest, Glenview 60025
	1972	Eugene T. Hoban, 6429 North Ave., Oak Park 60302
	1972	Fredric D. Lake, 1041 Michigan Ave., Evanston 60202
	1974	William M. Lees, 6518 N. Nokomis, Lincolnwood 60646
	1974	George Shropshear, 1525 E. 53rd, Chicago 60615
	1974	Philip G. Thomsen, 13826 Lincoln, Dolton 60419
	1973	Frederick E. Weiss, 15643 Lincoln, Harvey 60426
	1972	Warren W. Young, 3450 Haweswood Dr., Crete 60417
4TH District	1973	Fred Z. White, 723 N. Second St., Chillicothe 61523
5TH District	1973	A. Edward Livingston, 219 N. Main, Bloomington 61701
6TH District	1972	Mather Pfeiffenberger, State & Wall St., Alton 62002
7TH District	1973	Arthur F. Goodyear, 142 E. Prairie St., Decatur 62523
8TH District	1973	Eugene P. Johnson, 22 W. Main St., Casey 62420
9TH District	1972	Charles K. Wells, 117 N. 10th St., Mt. Vernon 62864
10TH District	1972	Willard C. Scrivner, 4601 State St., E. St. Louis 62205
11TH District	1974	Joseph R. O'Donnell, 444 Park, Glen Ellyn 60137

Chairman of the Board	Willard C. Scrivner, 4601 State St., E. St. Louis 62205
Trustee-At-Large	J. Ernest Breed, 55 E. Washington, Chicago 60602

Highlights of Convention



Dr. J. Ernest Breed, past president of ISMS, pauses to admire the Presidential medallion he has just presented to new ISMS President L. T. Fruin.

Attendance Totals

Attendance at the 131st Annual Meeting was as follows:

Physicians	1280
Guests	240
Auxiliary	309
Exhibitors	312
Medical Students	26
Allied Health Personnel	85
Total	2259

Memorial Service

A brief memorial service was conducted by Dr. Jacob E. Reisch, ISMS secretary-treasurer, for the 173 deceased ISMS members during the period between annual meetings. Personal notes of condolence were sent to families of the deceased.

President-Elect of AMA Auxiliary Addresses House

Mrs. C. Prentiss Lee, of Oregon, cited the warning, "Never underestimate the power of a woman" as a worthy slogan applicable to physicians' wives. Mrs. Lee said auxiliary members are capable of creating "climates of opinion" with the assistance of their physician-husbands. Mrs. Lee was installed as national president at the AMA's 48th Annual Convention in June.

Medical Assistants President Reports

Miss Jean Berschinski—president of the American Association of Medical Assistants, Inc.—Illinois Society—thanked Dr. Thomas Harwood, advisor to the group, on behalf of the 630 members, and announced the addition of two new county chapters—Cook County South and Champaign-Urbana.

Highlights of the year included participation in the ISMS President's Tour and the April Convention at which Elena Verdugo, "medical assistant" on the MARCUS WELBY, M.D. TV series was honored. Miss Berschinski declared active support for the Foundation for Medical Care and said the medical assistants plan workshops to acquaint themselves with FMC office procedures.

Mrs. Wilson West Describes Auxiliary's "4th R"—Responsibility

The theme of the Auxiliary in 1970-71 focused on responsibility, with particular emphasis on individual responsibility, according to Mrs. Wilson West, Belleville, president of the Woman's Auxiliary to ISMS. She reviewed the health education "Packaged Programs" developed by the national auxiliary and utilized on the state level.

Thirty-eight counties performed under the health manpower program, with 75 health career days in Illinois. Mrs. West said $5 million has been raised for the health careers program by the Auxiliary to the AMA and more than $10,000 in Illinois for AMA-ERF.

Mrs. West also announced the addition of a second new Auxiliary County Society in Southern Illinois—Williamson County Medical Auxiliary.



The Hamilton Teaching Award went to Dr. Benjamin W. Lichtenstein for his outstanding qualities as a teacher of medical students. Dr. Mather Pfeiffenberger (left) presents the award as Dr. Edwin Hamilton (center) looks on.



Pledging her group's support for the Illinois Foundation for Medical Care was Jean Berschinski, president of the Illinois Society of Medical Assistants, in an appearance before the House.



Dr. Philip G. Thomsen reviewed IMPAC's role in medical-political activities of the past year in his report to the House.



The Auxiliary's success in coordinating health education programs in the State was revealed by Mrs. Wilson West, president of the Woman's Auxiliary for 1970-71, in her remarks to the Delegates at the opening session of the House.

ISMS President Addresses House

Dr. J. Ernest Breed reviewed progress in the four areas presented in his inaugural address last year: Peer Review Committees have been established in the county societies: the proposed Council on Continuing Education has received continued study: 300 medical corporations were formed within the past year, bringing the total to approximately 1,000 in the state. These figures reveal that nearly half of all practicing Illinois physicians now work in groups. In terms of alerting the membership to malpractice threats, symposiums were presented throughout the state on this subject, during the President's Tour.

Dr. Breed discussed the problems besetting the Society and its members, the problems of pollution and population explosion call for careful analysis he concluded, since these factors will greatly increase the demands upon doctors.



The Gold Medal Award went to the exhibit, "Pedicle Flaps in Reconstructive Surgery," by Drs. M. Eugene Tardy, Jr., L. T. Tenta and N. J. Pastorek, Department of Otolaryngology, University of Illinois.

Scientific Exhibit Awards Presented

Gold Medal Award—*"Pedicle Flaps in Reconstructive Surgery"*
M. Eugene Tardy, Jr., M.D., L. T. Tenta, M.D., and N. J. Pastorek, M.D., Department of Otolaryngology, University of Illinois, Chicago.

Silver Medal Award—*"Diagnosis and Treatment of Common Bleeding Disorders"*
J. A. Caprini, M.D. and E. S. Kurtides, M.D., Evanston Hospital, Northwestern University Medical Center.

Bronze Medal Award—*"Pacemakers in Heart Disease"*
A. H. Khazei, M.D., I. Sejdinaj, M.D., and R. Powers, M.D., Sherman Hospital, St. Joseph Hospital, St. Alexius Hospital, Elgin.

University of Illinois Medical Alumni Awards To Four Physicians

Four physicians received University of Illinois Medical

Alumni awards during the joint President's Banquet and U. of I. Dinner Tuesday evening.

Honors went to Dr. Philip G. Thomsen, Dolton, past president of ISMS, for service to medical organizations; Dr. Theodore R. Sherrod, Chicago, for service to education research; Dr. H. Martin Engle, Chicago, for service to government; and Dr. Harold Mortimer, Las Vegas, for service to the practice of medicine.

Other Medical Society Presidents Attend Convention

Presidents from medical societies of four surrounding states attended the ISMS convention. They were: Dr. J. L. O'Brien, Iowa; Dr. M. O. Scamahorn, Indiana; Dr. George A. Behnke, Wisconsin; and Dr. Gerald D. Miller, Missouri.

AMA President Addresses House

Dr. Walter C. Bornemeier commented on his hopes for future doctors in terms of policies issued during his term in office as president of the nation's leading physician organization. He noted the present status of today's physicians and urged broad measures to meet today's problems.

Project HOPE Founder Speaks at Medical-Religion Symposium

Dr. William B. Walsh, founder and president of Project HOPE, addressed over 100 physicians and clergymen.

Dr. Leon P. Gardner, Joliet, and Rev. Richard W. Roth, River Forest, were presented awards for achievements in the areas of medicine and religion.

Hippies' Doctor "Tells It Like It Is"

Dr. David E. Smith, founder and medical director of the Haight-Ashbury Clinic, San Francisco, addressed a standing room only crowd on "Youth Alienation and the Drug Scene," at a special program.



The AMA-ERF check for Illinois' seven medical schools was presented to Richard Kessler, associate dean, Northwestern University Medical School, by ISMS President J. Ernest Breed.



Lt. Governor Paul Simon shared the speakers' platform with Mark Russell, Washington, D.C., political satirist, at the Annual Public Affairs Dinner on Monday evening.

Delegates To AMA Elected

Members of the AMA delegation elected to take office Jan. 1, 1972 and serve to Dec. 31, 1973 were: Edward A. Piszczek, Harold A. Sofield, Philip G. Thomsen, Jack L. Gibbs, Morgan M. Meyer, and Theodore Grevas.

Alternate Delegates to AMA elected to take office at the same time were Herschel L. Browns, George Shropshear, William M. Lees, Paul W. Sunderland, Glen E. Tomlinson, Charles K. Wells, and John Ring.

1972 Annual Meeting Site Announced

By combining with the Chicago Medical Society for the clinical section of the Annual Meeting in 1972, it becomes necessary to move the meeting date up to March 7-11. The Conrad Hilton Hotel, in downtown Chicago, will be the site of the ISMS House of Delegates meeting.

Delegates and Alternates to AMA Introduced

Dr. H. Close Hesseltine, chairman of the delegation, presented the AMA Delegates from ISMS: Edward W. Cannady, Carl E. Clark, Harlan English, Theodore Grevas, Maurice M. Hoeltgen, Joseph R. Mallory, Edward A. Piszczek, Harold A. Sofield, Philip G. Thomsen, and Francis W. Young.

AMA-ERF Check Presented to Illinois Medical Schools

Accepting the $113,938. AMA-ERF check for Illinois' seven medical schools, Richard Kessler, associate dean, Northwestern University Medical School, voiced appreciation in behalf of the schools.

Dr. Kessler described the goals of the Society and those of the schools as essentially identical, noting the dependence of the schools on ISMS. He revealed that Illinois, though third in population, is eighteenth on the list of



Dr. Anna M. Marcus presents Dr. Leon P. Gardner, of Joliet, a medicine-religion award, at the Medicine-Religion Symposium.

recipients for federal monies. He urged continued support as the State's medical schools prepare for the challenges facing them in terms of funds and government intervention.

Dr. Thomsen Reports on IMPAC's "Impact"

Dr. Philip Thomsen reviewed the image of today's doctors, who are made to look like "opportunists," and said that active involvement in medical legislation is the only way to "overcome those who condemn us."

Dr. Thomsen revealed that last year IMPAC tallied an 85% success rate in supporting state legislator candidates. He urged participation in political affairs through membership in IMPAC, and by contacting one's precinct captain. He cited these as solutions to the challenge presented by non-medical personnel who wish to accomplish changes through reform legislation rather than by training.

Hamilton Teaching Award Presented to Dr. Lichtenstein

Dr. Benjamin W. Lichtenstein received the sixth annual Hamilton Teaching Award for his outstanding qualities as a teacher of medical students. A plaque and $500 check were presented to the neurologist by Dr. Mather Pfeiffenberger, a member of the Board of Trustees of the Interstate Postgraduate Medical Association.

L. T. Fruin Inducted as ISMS President

Dr. J. Ernest Breed, in his last act as president of ISMS, administered the oath of office to Dr. L. T. Fruin, at the final session of the House of Delegates.

In his inaugural address, Dr. Fruin expressed anger over the health care problems besieging physicians today. He directed his anger at politicians who exaggerate the problems . . . labor leaders who claim doctors don't know how to deliver health care . . . patients' demands . . . and a society of physicians which ignores its own responsibility and allows malnutrition, drug addiction . . . racism to exist. (*See July,* IMJ *"Presidents Page" for abstract of inaugural address.*)

Foundations for Medical Care Approved by House

For the second time in the 130 year history of ISMS, the House of Delegates convened in special session to consider a major issue essential to the future of health care delivery in Illinois-Foundations for Medical Care.

The House held an open reference committee hearing on the issue before stamping its approval on the program. The first steps in establishing a foundation will be consideration of standards of care, designing a benefits package, and studying costs and fees. The state FMC should be ready for implementation within a few months.

Medical Writing Seminar—A Convention "First"

A "Seminar in Medical Writing," aimed at the physician-writer, was sponsored by the Greater Chicago Chapter of the American Medical Writers Association, with the cooperation of ISMS, on Saturday, preceding the convention.

Instructors included Dr. Charles Roland and Guy Whitehead, Ph.D., in the communications department of Mayo Clinic, and Dr. Lester King, senior editor of *JAMA*.

Physicians Test for "Gaps" in Medical Knowledge

Annual Meeting participants were provided the opportunity to uncover existing gaps in their medical knowledge at a medical self-testing exhibit.

Test materials included actual models, audio-visual



Picketing physicians urged delegates to contact state legislators on pending medical legislation.

aids, printed clinical simulations and computerized clinical problems. The program was developed by the Illinois Regional Medical Program, in cooperation with the University of Illinois Center for Education Development.

Public Affairs Dinner Combines Satire and Politics

Mark Russell, Washington political satirist, spiced the evening with his wry humor. Lt. Governor Paul Simon also addressed the audience at the Annual Public Affairs Dinner, Monday evening.

IMPAC Booth Gives Birth to "Picketing Physicians"

Physicians attending the House of Delegates sessions were urged to call their State legislators on pending bills detrimental to medicine. Encouragement to make calls came in the form of physicians bearing picket signs and by red, white and blue badges questioning, "I'VE CALLED! HAVE YOU?"



Admiring glances are cast upon the entry awarded a Blue Ribbon in the Physician Art Exhibit. Dr. James Kopriva, of Lake County, also received a Red Ribbon, second prize, for another painting he submitted.

Past presidents of ISMS paused for a group picture. (Standing from left): Drs. Harlan English, Edward A. Piszczek, George F. Lull, H. Close Hesseltine, Jacob E. Reisch, Newton DuPuy. (Seated from left) Drs. Leo P. A. Sweeney, Arkell M. Vaughn, Philip G. Thomsen, Edward W. Cannady, Edwin S. Hamilton, Everett P. Coleman.



Twelve new members joined the ranks of the ISMS Fifty Year Club at the Tuesday luncheon, where each received a certificate and pin.

Director of U.S. Mint Addresses Woman's Auxiliary

Mrs. Mary T. Brooks, director of the U.S. Mint, gave the ISMS Woman's Auxiliary a glimpse of life in the Treasury Department.

As the twenty-eighth director of the U.S. Mint, Mrs. Brooks is responsible for the manufacture and distribution of an adequate supply of coinage to meet the daily economic needs, as well as safeguarding the government's holdings of monetary metals and the refining of gold and silver, and special coin sets.

Mrs. Kweder Assumes Presidency of Woman's Auxiliary

Mrs. Adele Kweder, Waukegan, was inducted as president of the Woman's Auxiliary to ISMS at the 43rd Annual Meeting of the Auxiliary. Mrs. August Martinucci, Joliet, was named president-elect for 1971-72.



Summary of Actions of the 1971 House of Delegates

I. Special Reference Committee No. 1

Special Reference Committee No. 1 considered only the subject of Foundations for Medical Care for which a special session of the House was convened on May 15. After receiving the Reference Committee's report, the House took the following actions:

1. Declared unqualified support for the concept and implementation of foundations for medical care.

2. Agreed that ISMS should immediately establish a not-for-profit corporation to be called the Illinois Foundation for Medical Care and that it should encourage establishment of autonomous county and/or multi-county foundations for medical care under the sponsorship of local medical societies.

3. Resolved that the local and state foundations, together, shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

4. Opposed the use of any government funds to establish such foundations.

5. Instructed the Board of Trustees to borrow the necessary funds from other available non-governmental sources, with the loan to be repaid from operations of the foundation.

II. Amendments to the Constitution and Bylaws

Proposals to change the name of the House of Delegates to the "State Medical Forum" and to extend its responsibilities to include custodial duties were rejected as being inappropriate. The proposals were originally introduced in 1970, but referred to the Board of Trustees for further study.

The House also rejected a proposal to change the Bylaws to provide for affiliate societies to be represented in the House of Delegates, but it unanimously approved enlarging the Board of Trustees from 16 to 19 members by adding three trustees from the Third District.

Other changes in the Bylaws include:

Elimination of reference to the annual convention scientific program, which will be handled jointly next year by ISMS and the Chicago Medical Society; transferring responsibility for appointing ad hoc committees of the House from the President to the Speaker; and reworded the provision which allowed for the Vice Speaker of the House to assume the Speaker's duties on event of death or resignation.

In a technical correction, the House deleted reference to trustees as ex-officio members of certain committees no longer provided for in the constitution and bylaws. It also added the requirement that component societies should forward their list of officers, delegates and alternate delegates to the ISMS secretary before the first Wednesday in January each year.

In accordance with House actions establishing an FMC, the Bylaws were amended to allow the Board of Trustees to establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

Finally, the House adopted a recommendation that the name of the Council on Legislation and Public Affairs be changed to Governmental Affairs Council.

III. Officers and Administration

The House adopted the following policy recommendations of the Reference Committee on Officers and Administration:

1. Any council or committee recommending legislation to the attention of the Council on Legislation and Public Afiairs must provide expert witnesses when called upon to testify before Senate and House committees in support or in opposition to the legislation so recommended by the council or committee.

2. Reaffirmation of support for the AMA Medicredit legislation.

The House rejected efforts to limit the term of the ISMS secretary-treasurer and to prohibit ISMS members from holding more than one elected position at the state and/or AMA level simultaneously.

IV. Finances, Budgets and Publications

The House approved dues for 1972 with the following distribution of the dues dollar:

Operating Fund	$ 80
AMA-ERF	10
Independent Council on Contin. Educ.	10
Benevolence	5
	$105

It also approved a special assessment of $4 per dues paying member to mail the *Illinois Medical Journal* and *Pulse* to all Illinois SAMA members, interns and residents.

The House also adopted the following reference committee recommendations:

1. That ISMS dues billing forms be changed to include all the medical schools in Illinois and that ISMS request

the AMA to include these schools of medicine upon the AMA-ERF list for colleges eligible to receive this support.

2. That $10 per member be used to support for one year an independent council on continuing medical education.

3. That special cognizance be given to the Chicago Medical Society for its gift of $11,500 to the Benevolence Fund.

The House rejected a resolution which would have prohibited diversion of AMA-ERF funds from medical schools.

V. Economics and Social Services

The House adopted the following policies:

1. Endorsement of the American Medical Association's Current Procedural Terminology, Second Edition.

2. Encouragement of all medical staffs in Illinois to adopt as official policy a statement that any proposal or arrangement between institutional management and medical staffs should not conflict with principles of medical ethics or abridge the property right endowed upon the individual physician by the Illinois Department of Registration and Education.

3. Opposition to the principle of Chicago-based advisory services recommending to the Hospital Licensing Board in Springfield the construction and development of hospital and allied facilities outside metropolitan Chicago and reaffirmation of a position endorsing home rule Comprehensive Health Planning as a guide for upgrading local health facilities.

4. Opposition to AMA-endorsed texts recommending one drug or mixture of drugs over another.

5. Opposition to substitution of prescribed drugs except in cases of emergency or urgent need—unless there be full explanation and agreement both by patient and doctor.

The House rejected resolutions seeking extension of Medicare coverage to medicine bought outside a hospital and revision of the Illinois Relative Value Study, and it referred to the Nutrition Committee a resolution in support of the Low Standard Budget of the U.S. Department of Labor Statistics as guaranteed annual income in this state.

In addition, the House accepted a Reference Committee recommendation that instances of over-utilization and over-recruitment on the part of the Illinois Division of Vocational Rehabilitation be called to the attention of the Advisory Committee on Medical Costs and Utilization of Services created by S.B. 1139 and enacted by the 76th General Assembly.

VI. Education and Community Health Services

The following policies were adopted by the House:

1. Expansion of the SAMA-MECO Project, initiated in Illinois with the support of ISMS and now nationally recognized.

2. ISMS Delegates to the American Medical Association should urge the AMA to study the imbalance among different medical specialties and make recommendations to all U.S. medical schools and hospitals involved in medical education on control of the problem, distributing copies of the recommendations to all medical students.

3. ISMS should encourage the preventive medicine approach to the problem of unwanted pregnancies through encouragement of family life education in the schools; through wider dissemination of family life planning information including birth control information; and through encouragement of research in population control methods.

4. It is strongly recommended that ISMS members participate in the AMA Physicians' Recognition Award Program and the ISMS Committee on Continuing Education investigate the feasibility of making participation in continuing education programs a requirement for membership in the society.

5. The ISMS Board of Trustees is directed, through its Council on Education and Manpower and Council on Legislation and Public Affairs, to press for immediate enforcement of Illinois law requiring all medical schools receiving state funds to establish a Department of Family Practice. The resolution requires that action be instigated through the Executive and Legislative branches of the state government, the Illinois Board of Higher Education, the Board of Trustees of the University of Illinois, and the University of Illinois College of Medicine.

6. ISMS reaffirms the Boston agreement between the AMA and the American Red Cross which denies the Red Cross access to and permission to conduct donor mobiles in the counties of the State of Illinois without prior approval of the county medical society, and it directs the ISMS Board of Trustees to more closely scrutinize the blood procurement activities of the American Red Cross in Illinois.

7. Uniform physical examination forms should be developed for school employees, with appropriate medical criteria indicated for different positions.

8. Selected procedures may be performed on selected patients under general and local anesthesia as out patients. The Illinois delegation to the American Medical Association is instructed to propose that the AMA endorse this same principle.

9. Students admitted to medical schools in Illinois with advanced standing should be exempted from the attendance time requirement under the Illinois Medical Practice Act.

10. Seven statements on the prophylactic use of iron fortified foods, proposed by the ISMS Nutrition Committee were endorsed.

The House rejected a proposal to revise the ISMS policy on abortion and referred to the Council on Mental Health and Addiction a proposal to revise the chronic alcoholism provisions of the Illinois Mental Health Code.

The question of certifying nurse-midwives in Illinois was referred to the Committee on Allied Health Education.

VII. Legislation and Public Affairs

The House of Delegates expressed official concern over the increasing number of medical malpractice suits and their effect on patient costs by resolving that ISMS encourage the introduction and support of legislation aimed at reducing the mounting number of unjustified malpractice suits.

As a step toward alleviating physician shortages, the House said ISMS should seek or support legislation removing citizenship requirements from the Illinois Medical Practice Act to allow fully-qualified physicians to complete the examination normally given as a requirement for medical licensure, and upon the successful completion of which the non-citizen physician would be granted a license to practice medicine in all its branches providing he takes all necessary steps to obtain citizenship.

A resolution seeking elimination of the contingency fee in malpractice suits was referred to the Medical-Legal Council. The Council on Legislation was asked to study proposed recommendations on ISMS policy statements regarding county and multicounty health departments, their budgets, boards and operation in relation to established policy.

Resolutions requiring all state-supported medical schools to develop physician assistant training programs and one which named the Department of Public Instruction as the sole authority in matters relating to licensed practical nurse training programs were rejected. The reference committee recommended that it would be inappropriate for ISMS to seek legislation in either of these areas at this time. The House concurred.

The reference committee further recommended that ISMS members individually contact their legislators to express opposition to the following pending legislation:

- Broadening of the functions allowed optometrists, including diagnosis of all diseases of the eye.
- Mandatory vision examination of school children performed by optometrists and ophthalmologists that can be adequately handled by less costly screening. It was recommended that such screening be made mandatory.
- Requiring a permit from the Department of Public Health in order to construct a new hospital or long term care facility, add on to an existing facility or expand its services.

The House concurred.

VIII. Public Relations and Miscellaneous Business

The following actions were approved by the House:

1. Illinois delegates are requested to introduce a resolution at the 1971 annual AMA meeting recommending that Community Health Week be conducted in winter or spring.

2. The Board of Trustees is requested to appoint an ad hoc committee of delegates to study the problem of last minute introduction of resolutions in the House and the feasibility of establishing a cut-off date for their introduction so that component societies have time to review proposed actions.

3. ISMS recommends that the presence of the Sickle Cell Trait be considered by the armed services as a disqualifying defect.

4. ISMS favors the adoption of a modern medical examiner system for the entire state as a move to putting medical-legal examination on a scientific basis, replacing the present coroner system, and passage of such legislation will be sought.

5. ISMS officially endorses the Emergency Health Personnel Act of 1970, will solicit support and cooperation from County medical societies and local physicians for implementation of the act, and will submit a resolution to the AMA House of Delegates seeking concurring action.

6. The physician's draft should be considered an integral part of any and all draft reform proposals and similar action should be sought from an AMA House of Delegates.

7. Members of the Illinois Hospital Licensing Board, Director of the Department of Public Health, and the Coordinator of Health Services for the State of Illinois will be informed that the proposed construction of a 500-bed hospital in Mt. Vernon, Illinois is not in the best interests of good medical care and financing.

A resolution pertaining to requirements for ambulance service was referred to the Council on Environmental and Community Health and the Council on Governmental Affairs for action. A resolution involving the indiscriminate moving of elderly nursing home patients under the control of the Department of Public Health was referred to the Council on Medical and Social Services.

Actions on Resolutions 1971 House of Delegates

Number	*Introduced by:*	*Subject*	*Action*
71M-1	Rock Island Co.	Revision of Illinois Relative Value Study.	Rejected
71M-2	Michael Youssi for SAMA	Expansion of MECO Project	Adopted
71M-3	Michael Youssi for SAMA	Expansion of MECO Project	Adopted
71M-4	Wayne County	Need for Control of Imbalance Among Different Medical Specialties	Adopted as amended—Delete First Resolve

71M-5	Chas. J. Weigel for Coun. on PR & Membership Services	Community Health Week	Adopted as amended by Reference Committee
71M-6	A. Edward Livingston for 5th Dist.	Endorsement of AMA Current Procedural Terminology	Adopted substitute resolution per Reference Committee (same Sub. for 71M-19)
71M-7	Macon Co.	Revision in ISMS Abortion Policy	Rejected
71M-8	Macon Co.	Revision in ISMS Abortion Policy	Adopted as amended on the floor. (Last resolve insert on line 32 between words formation and birth the word "including" delete on line 32 words *and devices through a,* delete all of line 33, and delete on line 34 words *male and female.*)
71M-9	Fulton Co.	Foundations for Medical Care	No Action
71M-10	Cook Co.	Unify Mailing Addresses for County & State Societies	Adopted
71M-11	Cook Co.	Geographical Location of Physician Practice to determine County Society Membership	Withdrawn
71M-12	Rock Island	Revision of Illinois Mental Health Code Chronic Alcoholism Provision	Referred to Council on Mental Health and Addiction to report back to 1972 House of Delegates
71M-13	Joseph O'Donnell for Comm. on Health Care Financing	Foundations for Medical Care	Adopted
71M-14	Joseph O'Donnell for Comm. on Health Care Fin.	Foundations for Medical Care	Substitute resolution offered by Ref. Comm. adopted as amended: On Page 2 of Ref. Comm. Rep. line 35 between words available and sources add word "non-governmental," on line 36 following word Trustees, add "and be it further," strike out entire 2nd resolve, on line 42 add "s" to the word loan, strike words "from ISMS funds", on line 43 strike words "membership fees", add words "operation of the FMC."
71M-15	Jack Gibbs for Co. on Educ. & Manpower	Continuing Medical Education	Adopted
71M-16	Will-Grundy Co.	Impartial Medical Testimony	Withdrawn
71M-17	Will-Grundy Co.	Malpractice Suits	Referred to Medical-Legal Council
71M-18	Will-Grundy Co.	Mandatory Funding of H. of D.	Rejected
71M-19	Will-Grundy Co.	Current Procedural Terminology	Substitute offered by reference comm. adopted (Same Sub. for 71M-6)
71M-20	Will-Grundy Co.	Physician's Assts.	Rejected
71M-21	Will-Grundy Co.	Co. Health Depts.	Referred to Council on Legislation & P. A. with substitute resolves: Delete both resolves on original resolution. 1st resolve will be stated as in Ref. Comm. Report with addition of and be it further then add the following: RESOLVED, that budgets submitted by Boards of Health which fall within state limits of taxation shall be levied by county supervisors, and be it further RESOLVED, physicians appointed to Boards of Health shall be nominated by the County Health Society.
71M-22	Will-Grundy Co.	School Employee Physicals	Adopted
71M-23	Will-Grundy Co.	Dept. of R & E	Rejected
71M-24	A. J. Faber for Council on Leg. & P. A.	Providing expert witness for legislative testimony.	Adopted

71M-25	ISMS Bd. of Trustees	Agreements between Institutional Mgmt. & Med. Staffs	Substitute resolution as submitted by reference committee adopted
71M-26	Joseph R. O'Donnell for Com. on Health Care Fin.	Changes in ByLaws to permit establishment of FMC	Substitute resolution adopted as proposed by reference committee
71M-27	McHenry Co. Med. Soc.	Formation of Ad Hoc Comm. to advise on Health Plan. Fac.	Adopted as amended on the floor. In first RESOLVED eliminate Arabic "1" and add after last word on line 36 the following: and reaffirms its position endorsing home rule comprehensive health planning as a guide for upgrading local health facilities. Delete all the rest of the resolution. *SPECIAL NOTE:* Emergency resolution on the floor: RESOLVED that the resolution be sent to the state legislature immediately and physicians urged to contact their legislators.
71M-28	Madison Co.	AMA Drug Evaluation	Adopted
71M-29	Madison Co.	Foundations	No action
71M-30	A. J. Faber for Council on Leg. & P.A.	Const. & ByLaws	Adopted
71M-31	James Beuchler Clark Co.	Substitution of Prescribed Drugs	Adopted
71M-32	James Beuchler	Requirements for Ambulance Serv.	Referred to Council on Environmental Health and the Council on Governmental Affairs for action
71M-33	Will-Grundy	Tenure of Office	Not adopted
71M-34	Will-Grundy	Elected Officials	Rejected
71M-35	Kane Co.	Family Prac. Dept. at U. of Ill. Coll. of Medicine	Adopted as amended by reference committee
71M-36	Board of Trustees	Support of AMA Medicredit	Adopted
71M-37	Kane Co.	Procurement & Supply Blood	Adopted
71M-38	Will-Grundy	Foundation Memberships	Substitute resolution adopted as proposed by reference committee (same sub. for revised 71M-26)
71M-39	Will-Grundy	Autonomy of FMCs	No action
71M-40	Will-Grundy	Funding FMCs	Sub. resolution as offered by reference committee adopted as amended (same as 71M-14—See 71M-14 this report for amendment)
71M-41	Madison Co.	Payment of Defense Costs in Malprac. Suits	Substitute resolution adopted as presented by Reference Comm.
71M-42	Winnebago Co.	Maintenance of AMA/ERF Funds	Rejected
71M-43	Winnebago Co.	AMA/ERF Funds to new Ill. Med. Schools.	Adopted as amended by reference committee
71M-44	Winnebago Co.	Enf. Cut-off Date for resolutions	Adopted
71M-45	Wm. Ackley No. Sh. CMS	Suppt. Medicare Paymt. for Drugs & Med. Supplies for Aged	Rejected
71M-46	Kermit Mehlinger	Low Standard Budget	Referred to the Nutrition Committee for consideration and study
71M-47	Kermit Mehlinger	Sickle Cell Trait	Adopted as amended by reference committee
71M-48	Francis Young	Medical Examiners	Adopted
71M-49	Herman Wing	Out Patient Surgery	Adopted
71M-50	Mike Youssi	Emerg. Health Personnel Act	Adopted
71M-51	James Reid	IDPA-Nursing Home Patients	Referred to Council on Social and Medical Services
71M-52	Mike Youssi	Doctor Draft	Adopted as amended by reference committee
71M-53	ISMS Task Force On Phys. Shortage	Citizenship Lic. Requirements	Adopted as amended by reference committee
71M-54	Robert Hartman	Certification of Professional Nurse-Midwife	Referred to Committee on Allied Health
71M-55	Bordenave, et al	Proposed 500-bed hospital	Adopted
71M-56	Board of Trustees	Woman's Aux/AMA Pres.-Elect	Adopted without referral

what goes on

a guide to continuing education

July 16-17—UCLA Residential Conference Center

Course in Scientific Communication Set

Fee: $225. For information write: Continuing Education and Health Sciences, Room 15-39 Rehabilitation Center, West Medical Campus, University of California, Los Angeles, Calif. 90024 or call Mrs. Elizabeth Gifford at (213) 825-7186.

UCLA Residential Center, Lake Arrowhead

July 16-17—Rocky Mountain Cancer Conference

Cancer of the Head and Neck and the Newest in Chemotherapy

Co-sponsored by the American Cancer Society, Colorado Div. and Colorado Medical Society. Richard Jesse, M.D., Robert D. Lindberg, M.D., Robert W. McDivitt, M.D., Dr. R. Wayne Ruddles. For information write: Rocky Mountain Cancer Conference, 1764 Gilpin Street, Denver, Colo. 80218

July 17—American Association of Medical Clinics

North Central Regional Meeting

Holiday Inn, LaCrosse, Wisconsin

July 18-August 8—Diabetes Association of Greater Chicago

Summer Camp for Diabetic Children

Boys and girls from 8-13 are eligible. For applications and inquiries write: Diabetes Association of Greater Chicago, 620 N. Michigan Avenue, Chicago, Ill. 60611 or call (312) 943-8668.

July 29-30—Northwestern University Medical School

Post-Graduate Course in The Surgical Management of Gastrointestinal Disease

Registration is limited to 100. Forms are available from Dr. Jacob Suker, Department of Post-Graduate Education, Northwestern University-McGaw Medical Center, 303 E. Chicago Ave., Chicago, Ill. 60611. For further information call Dr. Jacob Suker at (312) 649-7947.

Offield Auditorium, Passavant Memorial Hospital

July 31-August 1—University of California Extension

Continuing Education of the Bar and Medical-Legal Society of Southern California

National Conference on Medical Malpractice and Doctor-Lawyer Relationships. Panels of doctors will discuss the prevention of medical malpractice suits, insurance coverage, and possible alternatives to the present system of malpractice litigation.
Overall objective of the conference is to promote better understanding between the two professions.
For further information write: California Continuing Education of the Bar, 2150 Shattuck Avenue, Berkeley, Calif. 95705.

August 7—Seventh Annual Athletic Injury Clinic

Sponsored by the Athletic Association of Southern Illinois University, Illinois High School Coaches Association of the U. of Illinois, and ISMS.
Registration is free for athletic directors, coaches, trainers, physicians and therapists. Program begins at 8:30 a.m.
The program will include: General Aspects of Injury; Insurance & Liability; The Ankle; Head & Neck; Heat Illness; The Knee; Abdominal Injuries; and Therapy

Auditorium, Lovejoy Library, Southern Illinois University, Edwardsville Campus.

August 11-15—University of California Extension

Advanced Seminar in Urology

For information write: Donald Brayton, M.D., associate dean, post graduate medical education, Room 15-39 Rehabilitation Center, West Medical Campus, University of California, Los Angeles, Calif. 90024, or call Miss Kathleen Blake at (213) 825-7257.

The month in Washington

From the Washington Office, American Medical Association

The House Ways and Means Committee has approved the Social Security Amendments of 1971 (medicare and medicaid changes) and sent the massive health bill to the floor of the House for expected early passage.

As adopted by the committee, the bill concerns itself with the implementation of the Administration's Health Maintenance Organization option for medicare beneficiaries, restricts physicians' fee increases under federal programs, reduces some long-term medicare benefits, and covers under Medicare for the first time disabled social security beneficiaries.

Medicare beneficiaries would be permitted to have all covered care provided by a Health Maintenance Organization (HMO), defined as a prepaid group health or other capitation plan, with the government reimbursing the HMOs at 95 per cent of the average cost of medicare beneficiaries in the area.

Physicians' medicare fees would be pegged at the 75th percentile of actual charges in a locality and future increases would be tied to a special index reflecting rising costs. The Department of Health, Education and Welfare could terminate payments to providers found guilty of program abuses.

A medicare co-insurance factor, one-eighth of the hospital deductible, would be applied after the thirtieth day. The medicare part B deductible would rise to $60 a year and medically indigent persons above the poverty level could be required by the states to pay an income-related premium.

The House Committee on Interstate and Foreign Commerce has approved a three-part health bill designed to meet the national shortage of medical personnel by 1978.

The proposed legislation would authorize an estimated $3.3 billion in aid to health profession students and their schools in the next three years and provide the facilities and programs to close the manpower shortages in the health professions within seven years.

The nation's financially beleaguered medical schools would receive $11,500 for the full-term cost of training each student, an action long urged by the American Medical Association.

Under the legislation expected to pass the house in substantially the same form each school would receive $2,500 per student per year for the first three years of training. The grant rises to $4,000 for the final year. In order to encourage swifter training, three-year schools would receive the same total as four-year schools, but the final year figure would be $6,500.

Each school must enroll an additional five per cent of students, or ten whichever is the greater, to qualify for assistance. An extra $1,000 will be awarded schools for each student exceeding this total. The measure will also help establish at least five new medical colleges.

Additional authorizations would provide $270 million for health manpower initiative awards to establish health education centers, and $412 million for special project grants for programs in family medicine, physician assistant training, and others. The bill continues support for scholarship and student loans at increased levels.

The Justice Department has cracked down on the widespread abuse of "pep pills" by proposing the reclassification of amphetamines and methamphetamines so as to require that they fall in the category of non-refillable prescriptions.

The action would regulate amphetamines and methamphetamines as narcotic substances such as morphine, codeine, and opium as they carry a potential for "severe psychological dependence" with "serious danger" to abusers.

Manufacturing quotas geared to estimated legitimate use and the filing by manufacturers of order forms would be required. However, at least one major manufacturer has endorsed the proposal.

President Nixon recently signed into law a $6.9 billion supplemental appropriation bill containing an additional $100 million for cancer research. The "cancer cure" program would have an independently budgeted research unit within the National Institute of Health with a director reporting directly to the President.

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Viewbox . . .

(Continued from page 35)

DIAGNOSIS: *Ewing's sarcoma.* The interest in this case is the fact that all five diagnoses were suggested by various radiologists who reviewed the film, illustrating the diagnostic difficulties accounted in the diagnosis of bone tumors. There are certain radiographic characteristics which are very useful in a diagnostic evaluation of a specific lesion; however, the ultimate diagnosis rests with the microscopic pathology.

In Ewing's sarcoma the most common sites of presenting lesion are in the innominate bone or in a long tubular bone. The usual history elicited, is pain which can be several months or up to a year in duration and of increasing degree and frequency. The peak age incidence is about 15 years of age, and the tumor is rarely seen below the age of five years or over the age of 30. The characteristic radiographic appearance, which has been described, is ordinarily evidence of bone lysis not associated with much reactive new bone formation; however, in occasional presenting lesions, (such as our case) one will find that much of the lesional area is relatively radioopaque. The radioopacity is a result of new bone formation at the lesional site. This new bone formation represents a locally reactive osteosis as Ewing's sarcoma tissue itself has no osteogenic potentialities. Occasionally one will see a so-called classical case with onion skin-like periosteal new bone apposition; however, this does not have to be pathognomonic of Ewing's tumor. It frequently metastasizes to other bones and there is some question as to whether there are multicentric foci. The patient expired one year after the initial diagnosis was made.

Anovulatory infertility

(Continued from page 49)

10. Crooke, A. C., Butt, W. R., and Bertrand, P. V.: "Clinical trial of human gonadotropins (I, II, III)," *Acta Endocrinologia,* 53: Suppl. III, 1966, and *J. Obstet. & Gynec. Brit. Comm.,* 71:571, 1964.
11. Sherman, R.: Human Ovulation Induction. Charles Thomas Co., Springfield, Ill. 1969.
12. Marshall, J. R., and Hammond, C. B.: "Dose Response Relationships of Ovulation Induction with Human Menopausal Gonadotropin," *J. Clin. Endo. & Metab.,* 29:106, 1969.

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

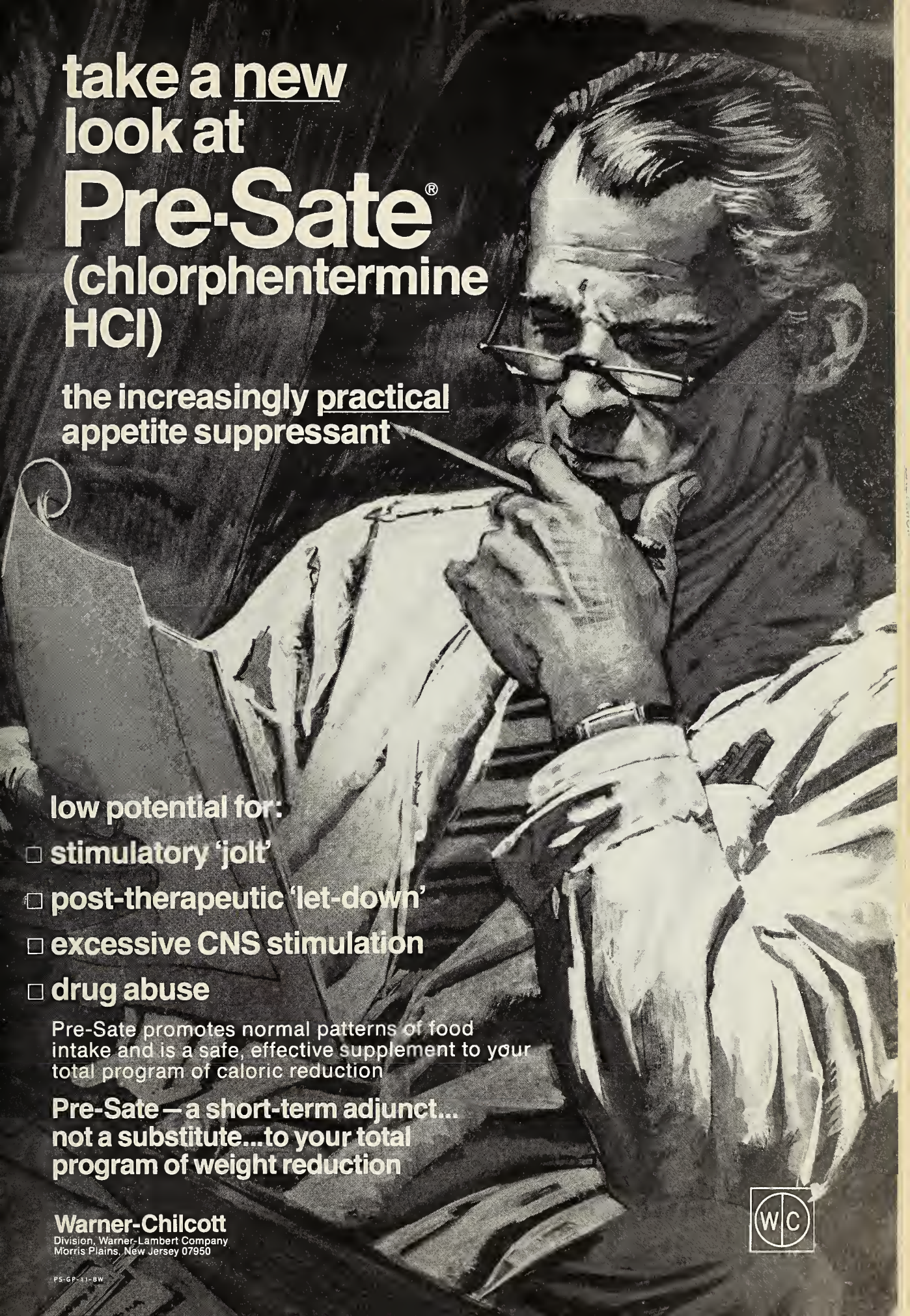
Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

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Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

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report

a service of the illinois medical assistants association

What I have gained by belonging to IMAA

By Luella Mitchell/Chicago

1956 was a very memorable year for me. That is the year I joined the Chicago Medical Assistants Association, which made me a member of the Illinois Medical Assistants Association and the American Association of Medical Assistants. As a member I have become a more competent Medical Assistant.

In the days of "yore" doctors trained their own "girls." Where is the physician, even if he had the time, who can instruct his Medical Assistant in mastering dictating machines, accounting procedures, collections and credit, insurance forms, purchasing, telephone techniques, reception room politeness and all the inevitable complexities of computerized central record controls, patient histories and personality improvement which might reverse, thereby leaving the Medical Assistant in tears and fury?

Also where is the physician who has the time to tutor on anatomy, physiology, preparing patients for examination, professional ethics, medical terminology, spelling and correspondence?

As a member of the Illinois Medical Assistants Association, my physician-employer did not have to give his time in training, because these are the things you learn by belonging.

I was encouraged by my physician-employer to become a member of this organization that is dedicated to improving Assistants by constant education and training. He paid my dues and now feels he has received countless returns on his investment.

I used to be a "Girl Friday," today a "Girl Friday" is as obsolete as yesterday's medical practice. With increasing complexity in medical advances, the Medical Assistant must truly be "with it." The Medical Assistant is now a member of the medical team, acutely aware that it takes the cooperation of every member of the team if the doctor and the patients are to receive the kind of service exemplified in the free enterprise system of American medicine.

If other doctors are interested in their aides deriving as much as I have from being a member, they will insist they too become members of the Illinois Medical Assistants Association.

For further information contact Mrs. Norma Domanic, 150 Ash Street, New Lennox, Illinois 60451, or Mrs. Vivian Kraft, R.R. 2, Normal, Illinois 61761.

One goes in . . . 5.7 go out

For every patient admitted to a hospital in 1970, there were 5.7 outpatient visits, reports the American Hospital Association. Ambulatory care continues to be the fastest growing service in the nation's hospitals.

In 1970, the 7,123 hospitals registered by the American Hospital Association reported a total of 181.4 million outpatient visits for an increase of 11.1 per cent over 1969.



socio-economic news

a service of the division of health care delivery

By Joseph J. Lotharius

Illinois FMC Gets legal status

The Illinois Foundation for Medical Care became a legal entity within a week after ISMS Delegates approved its establishment. The newly formed organization filed articles of incorporation with the Secretary of State's office in late May. The Foundation's interim Board of Directors are presently making plans to draft by-laws. These plans include scheduling a meeting at which local physician leaders will be encouraged to express their opinions about the by-laws' content. Particularly significant will be local views about the relationship with the state Foundation, representation on the state Board of Directors and charters to local Foundations from the state FMC.
(Editor's note: The July issue of *Pulse* contains more detailed information on FMCs including a progress report on local Foundations.)

ISMS opposes Mt. Vernon medical Center

Despite bitter opposition from a large group of Mt. Vernon, Ill. residents, city councilmen voted to support a proposed 500-bed medical center to be built in that city. ISMS' House of Delegates agreed with local residents on this controversial issue and adopted a resolution opposing the center because it was not in the best interests of good medical care. The ISMS position on this issue has been announced to members of the Hospital Licensing Board, the Director of the Department of Public Health and the Coordinator of Health Services of Illinois. According to information reported to ISMS, plans for the new hospital were completed without consulting physicians or other hospitals in surrounding counties that will be affected by the new installation.

Contracts between MDs and institutions May be unethical

Physicians should be wary of conflicting with the Principles of Medical Ethics when they make any contractual arrangements with institutions.

This note of caution was voiced by ISMS Delegates at the annual convention who requested that it be called to the attention of physicians on medical staffs throughout the state. The action taken by the Delegates is particularly timely because of the various new proposals of health care delivery which invite physicians to participate in hospital or institution-based health maintenance organizations.

ISMS Delegates said a physician's medical license constitutes a property right which should not be abridged in any contractual relationship.

AMA's coding procedure Endorsed by ISMS Delegates

ISMS Delegates formally endorsed AMA's *Current Procedural Terminology,* (2nd Edition), during the recent annual convention.

The CPT, a five digit coding procedure, has been in use for about a year by several insurance carriers and the Illinois Department of Public Aid. Delegates said a standardization of coding procedures is highly desirable in Illinois and throughout the country.

Presently, many coding procedures are being used including the California Relative Value Studies of 1964 and 1969.

ISMS endorses Emergency Health Personnel Act

Endorsement of the Emergency Health Personnel Act which would permit medical school graduates to fulfill their military obligation by serving in medically indigent areas was voted by ISMS Delegates. State Society support for this national legislation was requested by SAMA.

News of the action taken by ISMS on this question was sent to AMA for concurring action, and to all individuals and agencies concerned with the implementation of this legislation.

A day in the hospital totals up to $81.01 in '70

The cost of providing care for one hospital patient for one day in 1970 was $81.01, the American Hospital Association reported recently. This represents a 15.7% increase over 1969.

Reports from the nation's 5,859 community hospitals showed total expenses at a new high of $19.6 billion. In 1969, the expenses totaled $16.6 billion. The complete report on trends in hospital utilization, personnel and finances will be contained in the annual Guide Issue of *Hospitals, Journal of the American Hospital Association,* published August 1.

Hospitals are feeling the inflated state of the national economy, according to Edwin L. Crosby, M.D., executive president of AHA.

"The inflationary spiral of the nation's economy has played a large part in the rise of hospital costs. Everything hospitals buy costs more than it did a year ago. And wages and salaries continue to increase."

The 1970 occupancy rate for community hospitals showed a small drop from 78.8 per cent (in 1969) to 78 per cent (in 1970). Average length of stay decreased one-tenth of a day from 8.3 to 8.2 days.

ekg of the month . . .

(Continued from page 54)

ANSWERS (1, 3 and 4):

1. Examination of the tracing reveals premature atrial beats.
 a. The 3rd QRS complex to be normal but premature.
 b. This QRS is preceded by a P' wave, i.e. it does not precisely resemble the other P waves in the strip.
 c. The interval following this QRS is slightly longer than the normal R-R interval.
3. No R wave is seen in V_1 and V_2. A small Q is present in V_3. The S wave is notched in V_2. These features are suggestive of a transmural antero-septal infarct remote in time since no acute ST-T segment changes are present.
4. The history of increasing dyspnea on exertion and the physical evidence of basal moist rales and a S_3 (ventricular gallop) sound, all suggest left ventricular failure. In addition, ectopic atrial rhythms of all varieties commonly accompany LV failure.

the presidents page

(Continued from page 8)

cine who wonders if he will ever catch up while being crushed under an increasingly heavy caseload."

Dr. Fruin said that if the government steps further in to the health care business 10 or 12 percent of the practicing physicians of this nation will quit because they will "refuse to be cogs in a bureaucratic machine."

"If that happens, that would leave less than 200,000 of us to care for more than 200 million Americans. Physicians now work an average of 65 hours a week . . . the average American works 39.5 hours per week."

Dr. Fruin said that if doctors ever decide—because of governmental controls—to work a 40-hour week, it would mean an immediate 30 to 35 percent reduction in manpower.

"At the present rate of physician-per-week output, that means we would be left with the equivalent of only 140,000 physicians," Dr. Fruin said. "They would be saddled with a system which calls for more service than can be provided. It would be an impossible situation."

Dr. Fruin said physicians predicted the flaws in Medicare "which are apparent today . . . spiraling costs, unrealistic demands for care, administrative blunders and the severe shortage of personnel."

He criticized a recent letter from state officials warning that if physicians don't cooperate in limiting hospital stays and services under Medicaid, "undesirable limitations" might be imposed later.

"What they're saying is that if we don't lower the quality of our medical care, we will bear the consequences.

"But we cannot bend. *The medical profession must be allowed to maintain control over the standards of medical care and the determination of allowable departures from these standards. We are the only ones in a position to make these judgments.*"

Proposes "Policy Evaluation Committee"

Recognizing the plight of physicians who feel they have little or no voice in ISMS affairs, Dr. Fruin proposed the creation of a "Policy Evaluation Committee" to seek out and capitalize on undeveloped ideas that often go to waste.

"It would not replace existing ISMS programs . . . it would be a sort of 'hot-line' to ISMS leadership, an effective channel through which constructive criticisms and ideas can be heard."

Other goals for the year listed by Dr. Fruin include:

- "That we redouble our efforts to tell the public both sides of the health care story.
- "That we make the foundation plan a practical reality in Illinois with the full support of our membership and the public.
- "That we prove . . . once and for all . . . that it is the PHYSICIAN who can best plan . . . and deliver quality health care at reasonable costs."

L. J. Fruin M.D.

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Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 16 manuscript pages,** (including illustrations) and should be briefer if possible.

References should be numbered and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author (s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

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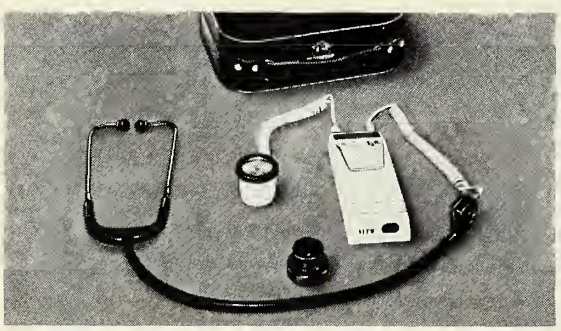
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STARTING DATES—1971

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SPECIALTY REVIEW COURSE IN MEDICINE, Part I, Sept. 13
SPECIALTY REVIEW COURSE IN NEUROLOGY, Clinical, Sept. 13
SPECIALTY REVIEW COURSE IN THORACIC SURGERY, Oct. 4
SPECIALTY REVIEW COURSE IN OB-GYN, October 25
ADVANCED PERIPHERAL VASCULAR SURGERY, One Week, July 12
MANAGEMENT OF COMPLICATIONS IN SURGERY, 4 Days, Sept. 14
SURGERY OF THE HAND, Three Days, September 15
PEDIATRIC SURGERY, One Week, September 27
PRE AND POSTOPERATIVE CARE, 4 Days, October 5
SURGERY OF THE G.I. TRACT, One Week, November 1
COSMETIC & TUMOR SURGERY OF HEAD & NECK, One Week, Nov. 8
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Methemoglobin.....

(Continued from page 44)

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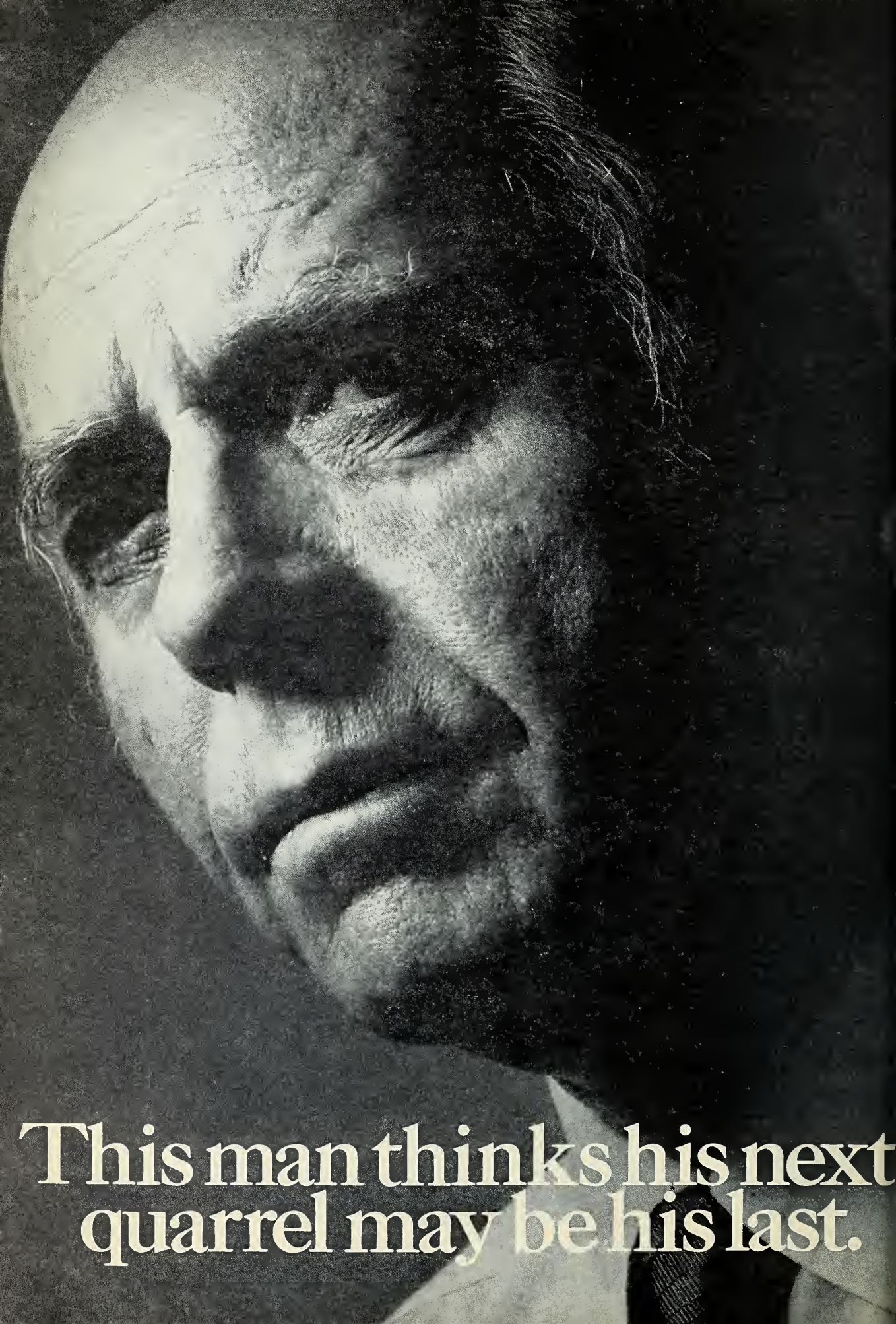
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This man thinks his next
quarrel may be his last.

BLUE SHIELD REPORT FOR Illinois Physicians

Outpatient Surgery—Long A Blue Shield Benefit

During the recent Annual Convention of the American Medical Association, the House of Delegates took action on a resolution introduced by the Illinois delegation. The resolution, noting the increase in the backlog for inpatient admission, the use of hospital beds, and the cost of medical care and acknowledging the increasing safety of performing certain surgical procedures on an outpatient basis, endorsed the "concept of outpatient surgery under general or local anesthesia for selected patients as good medical practice."

The value of outpatient surgery in reducing the expenditures for medical care by the patient and in freeing needed hospital beds has long been recognized by the Blue Shield Plan of Illinois Medical Service. Since early in its history, Illinois Blue Shield has provided benefits for surgical procedures performed in the outpatient department of a hospital, a physician's office, a clinic, or the patient's home.

The first Blue Shield Indemnity certificate, the "General Certificate", was issued in the early 1950's and provided benefits for surgery performed in the outpatient department of a hospital or in a physician's office but limited coverage to sixteen named procedures. A few years later the "Series C Cerificate", the first alternative to the "General Certificate", was issued and provided for surgical benefits without limiting the procedures or place of treatment.

In 1960, Illinois Medical Service offered the "Series H" and "Series I" certificates which provided benefits for surgery wherever performed. These "Series H and I" certificates are our major indemnity offerings today.

Benefits for surgical services wherever performed were included in the Usual and Customary certificates, first issued by Blue Shield in 1967. Then, in the late 1960's, the "General Certificate" was revised to broaden the covered services.

Today, all certificates available under the Blue Shield Plan of Illinois Medical Service pay for covered surgical services wherever performed.

As a further support of the concept of outpatient surgery, Blue Shield has joined with physicians at St. Joseph's Hospital in Joliet to encourage the performance of more surgical procedures on an outpatient basis. Under this experimental program, begun nearly two years ago, diagnostic cervical dilitation and curettage procedures were performed for selected patients in the outpatient department.

The response to the program was so great that ten or twelve additional procedures were added. These include esophagoscopy, bronchoscopy incision and drainage of the ear drum with or without teflon insert, excision of skin lesions, submucous resection of the nasal septum, minor hand and foot surgery, small skin grafting procedures, minor orthopedic procedures such as removal of screws and wires and treatment of simple fractures, and other surgical procedures of similar magnitude.

The initiation taken by Blue Shield in providing coverage for these procedures and the overall success of the program has encouraged commercial carriers in the area to join the program by providing similar benefits.

It is through such programs as the one in Joliet that Blue Shield continues to explore ways to make optimum use of health care facilities for the benefit of the patient, the doctor and the community.

Blue Shield—Part of a Total Community

The Community Affairs Department of Blue Cross and Blue Shield was organized in 1968. Joining with many social agencies, its staff is working to solve the problems facing both urban and rural society today. In its search for solutions and ways in which Blue Shield and Blue Cross can be of help, the department contributes manpower and the vast fund of experience in health care matters Blue Shield and Blue Cross have gained over the years.

One recent contribution of great importance was the department's participation in the Illinois Conference on Food, Nutrition and Health. Following the White House Conference on Food, Nutrition and Health, more than 1000 members of the Illinois community participated in five regional meetings, plus a statewide convention held at the University of Illinois. Each meeting provided a forum which sought solutions to the cause of hunger and poor nutrition and provided recommendations for a total food, nutrition and health program covering diet, health education and consumer motivation—a program which would aid the total community in Illinois.

(This is not an advertisement)

ASK BLUE SHIELD
• • • ABOUT MEDICARE

Part B Medicare Coverage for Diagnostic Services

Benefits are available under Part B Medicare for diagnostic x-ray, laboratory, and other diagnostic tests. Diagnostic x-rays and other diagnostic tests, except in the circumstances indicated below, must be furnished by a physician or as incident to a physician's service to be eligible for payment under Medicare. Diagnostic laboratory services are covered when furnished by a physician in a laboratory adjunct to his practice or by an independent laboratory which is a Social Security Administration approved Independent Clinical Laboratory.

When billing for diagnostic service obtained from a laboratory outside his office, the physician *must identify the laboratory where the services were obtained* on the bill or on the SSA 1490, Request for Medicare Payment form.

According to the Social Security Administration, an independent laboratory is one which is not connected with either an attending or consulting physician's office or a hospital which meets at least the requirements to qualify as an emergency hospital. A clinical laboratory is one where microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, or pathological examinations are performed on materials derived from the human body to provide information for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.

A laboratory which serves hospital patients and is operated on the premises of a hospital which meets the definition of an emergency hospital is presumed to be subject to the supervision of the hospital or organized medical staff and is not an independent laboratory. A laboratory which a physician or group of physicians maintains for performing diagnostic tests in connection with his own or the group practice is also not considered an independent laboratory.

Medicare will make payment to independent laboratories only for the performance of diagnostic tests in the specialties for which the laboratory is certified. Payment requests for any other tests will be disallowed.

The taking of an electrocardiogram tracing in an approved laboratory is a covered service because the actual taking does not require the supervision of a physician. However, the EKG must be ordered and interpreted by a physician and the person taking the tracing must meet at least the qualifications for a laboratory technologist or technician.

Physician ordered diagnostic services performed by a qualified psychologist practicing independently of an institution, agency, or physician's office are covered as "other diagnostic tests". However, there is no coverage available for psychotherapy performed by a privately practicing psychologist.

"Other diagnostic tests" also include diagnostic testing performed by a qualified audiologist when a physician orders such testing to obtain additional information necessary for his evaluation of the need for or the appropriate type of medical or surgical treatment for a hearing or related medical problem. However, where the medical factors required to determine the appropriate medical or surgical treatment are known and tests are conducted for the purpose of determining the need for or the appropriate type of hearing aid, the services are excluded whether performed by a physician or non-physician.

Benefits for psychological or otological evaluation may be obtained by accepting assignment or by presenting the patient with an itemized statement. In either case, the name of the physician who ordered the tests *must* appear on the statement.

Limitation on Injections

Injections of medications administered for treatment of disease which exceed the frequency and duration indicated by accepted standards of medical practice as an appropriate level of care for that condition are not covered under Part B Medicare unless there are extenuating circumstances which justify the need for additional injections.

For example, where standard medical practice indicates the use of parenteral penicillin or other antibiotics for the initiation of, but not for the entirety of, the course of treatment of an infectious disease, the entire charge for those penicillin injections exceeding the initial standard dosage would be excluded from payment unless there were special medical circumstances which justified the additional injections.

SSA Changes in Lab Certification

The Social Security Administration no longer considers the following laboratories certified for Medicare participation:

Palos Medical Laboratory
12150 South Harlem Avenue
Palos Heights, Illinois 60463

Pasco Medical Laboratories #26
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Chicago, Illinois 60602

Maryhaven Medical Laboratory
8700 South Dante Avenue
Chicago, Illinois 60617

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103 Haven Road
Elmhurst, Illinois 60126

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move up to "the Robinul response"

In treating hypersecretion and hypermotility associated with gastritis are you disappointed in the results you've been getting with some of the synthetics? Then *move up* to a potent anticholinergic—Robinul® Forte (2 mg. glycopyrrolate). It provides prompt, pronounced, prolonged suppression of gastric hypersecretion, making it a highly effective agent in gastritis and other upper G-I conditions associated with hypersecretion and hypermotility. Because Robinul Forte exerts a profound antispasmodic action, it is also useful in the treatment of lower G-I disorders, such as functional bowel distress and spastic and irritable colon. If the patient has a "one tract mind" concerning his condition, you can help control the anxiety and tenseness by prescribing Robinul®-PH Forte (2 mg. glycopyrrolate with 16.2 mg. phenobarbital —warning: may be habit forming).

Robinul® 2 mg. Forte (glycopyrrolate)

INDICATIONS Robinul Forte (glycopyrrolate, 2 mg.) and Robinul-PH Forte are double-strength dosage forms of glycopyrrolate. They are primarily ıdicated for patients who are less responsive to anticholinergic therapy and for control of the more prominent symptomatology associated with cute episodes of gastrointestinal disorders. Emphasis should be on total management, with due consideration of the various therapeutic modalities vailable, including diet, antacids, anticholinergic agents, sedatives, and attention to emotional problems. Accordingly, glycopyrrolate is recom-ıended in the management of gastrointestinal disorders amenable to anticholinergic therapy, such as: (1) duodenal ulcer, duodenitis, pylorospasm; 2) gastric ulcer, gastritis, esophageal hiatal hernia, hyperchlorhydria, pyrosis, aerophagia, gastroenteritis; (3) esophagitis; (4) cholecystitis, chronic ancreatitis; (5) spastic and irritable colon, ulcerative colitis, functional bowel distress, diverticulitis, acute enteritis, diarrhea; and (6) splenic flexure yndrome, neurogenic gastrointestinal disturbances. When these conditions are associated with psychic overlay, the formulation with phenobarbital ıay be indicated. ■ **CONTRAINDICATIONS** Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric reten-on, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH orte (glycopyrrolate with phenobarbital), sensitivity to phenobarbital. ■ **PRECAUTIONS** Administer with caution in the presence of incipient laucoma. ■ **SIDE EFFECTS** The most frequent side effect noted during clinical trials was dry mouth. Thirty-three (3.3%) of 1,009 patients receiving to 32 mg. of glycopyrrolate a day complained of dry mouth of moderate to severe degree, but only 11 discontinued treatment because of this. lurred vision, constipation, and urinary hesitancy have been reported infrequently. Other side effects associated with the use of anticholinergic rugs include: tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsi-ess, and rash. ■ **DOSAGE** The average and maximum recommended dose of Robinul Forte (glycopyrrolate, 2 mg.) or Robinul-PH Forte is one ıblet three times daily (in the morning, early afternoon, and at bedtime). To obtain optimum results, dosage should be adjusted to the individual atient's response. After the more severe symptoms associated with acute conditions have subsided, the dose may be reduced to the minimum equired to maintain symptomatic relief. ■ **SUPPLY** Robinul Forte (glycopyrrolate, 2 mg.) is available as scored, compressed pink tablets engraved HR/2 in bottles of 100 and 500. ■ Robinul-PH Forte (glycopyrrolate, 2 mg., with phenobarbital, 16.2 mg.) is available as scored, compressed blue ıblets engraved AHR/2 in bottles of 100 and 500.

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Obituaries

***Dr. Willis Bowers,** Granite City, died June 12 at the age of 57. He was a member of the ISMS Committee on Aging.

Dr. Edward A. Welch, formerly of Marion, died May 15.

***Dr. Daniel G. Cariss,** Granite City, 59, died May 20. He was a staff member of St. Elizabeth's Hospital, Granite City.

***Dr. Ervin G. Mertes,** Streator, died May 26, at the age of 50.

Dr. Angelo A. Aierilio, Chicago, died June 27. He was a staff member of St. Francis Xavier Cabrini Hospital for over 30 years, and also served as a staff member of Columbus Hospital.

***Dr. Stanley D. Swiontkowski,** Chicago, died June 3, at the age of 65.

***Dr. George Galambos,** Skokie, died June 3.

Dr. Susan J. Johonnott, formerly of Solon Mills, died May 30, at the age of 30.

****Dr. Peter J. Werner,** Chicago, died June 10, at the age of 74.

****Dr. Henry Scott,** Park Forest, died June 13, at the age of 99.

***Dr. Max E. Engerman,** Chicago, died June 21, at the age of 77.

Dr. Gregio Sicord, Chicago, died June 21, at the age of 61.

Dr. H. G. Wheringer, Chicago, died June 21, at the age of 77. He was on the staff of Norwegian American Hospital.

***Dr. Henry M. Goldstein,** Chicago, died June 15.

Dr. Vija Berins, Chicago, a North Side psychiatrist, died July 4, at the age of 28.

Dr. Edward A. Rubin, Chicago, died in July

Dr. Edward E. Seidmon, Plainfield, New Jersey, formerly of Chicago, died July 6, at the age of 64.

Dr. Hunter Collins, Willmette, died July 5, at the age of 89.

****Dr. George F. McIntyre,** Fort Lauderdale, a retired Chicago, eye, ear, nose and throat specialist, died July 4, at the age of 77.

Dr. Joseph J. Alesi, Chicago, died July 4.

***Dr. Fred F. Porter,** 43, Northbrook died July 6.

**Member of ISMS*
***Member of the ISMS Fifty-Year club*

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.

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(fluoxymesterone, Upjohn)

Orally active androgen about 5 times as potent in anabolic and androgenic activity as methyltestosterone. Halotestin (fluoxymesterone) induces significant retention of calcium and potassium, but retention of sodium not marked. Doses below 20 mg. daily have little effect in producing creatinuria.

Indications *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.

Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.

Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.

Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.

Supplied *Tablets: 2 mg.*, scored—bottles of 100./*5 mg.*, scored—bottles of 50./*10 mg.*, scored—bottles of 50.

For additional product information, see your Upjohn representative or consult the package circular.

Upjohn The Upjohn Company, Kalamazoo, Michigan

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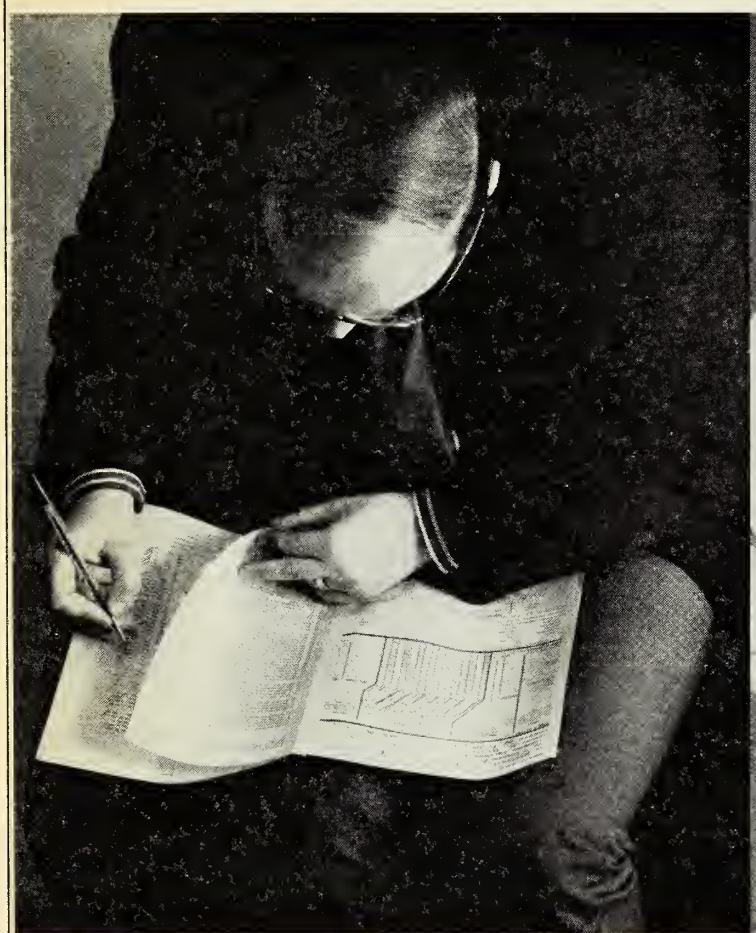
Estimated cancer deaths by state for 1971 from American Cancer Society

Alabama	5,000
Alaska	200
Arizona	2,400
Arkansas	3,300
California	30,000
Colorado	2,700
Connecticut	5,100
Delaware	800
D. C.	1,600
Florida	13,200
Georgia	6,100
Hawaii	800
Idaho	1,000
Illinois	19,300
Indiana	8,400
Iowa	5,000
Kansas	3,800
Kentucky	5,100
Louisiana	5,500
Maine	1,900
Maryland	6,300
Massachusetts	10,800
Michigan	13,800
Minnesota	6,200
Mississippi	3,400
Missouri	8,600
Montana	1,100
Nebraska	2,700
Nevada	600
New Hampshire	1,400
New Jersey	13,300
New Mexico	1,100
New York	36,000
North Carolina	6,600
North Dakota	1,000
Ohio	18,100
Oklahoma	4,300
Oregon	3,400
Pennsylvania	22,500
Rhode Island	1,900
South Carolina	3,200
South Dakota	1,100
Tennessee	5,900
Texas	15,800
Utah	1,100
Vermont	800
Virginia	6,400
Washington	5,200
West Virginia	3,200
Wisconsin	7,600
Wyoming	400

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AMA House action on Illinois resolutions

The ISMS delegation to the American Medical Association, consisting of 12 delegates and eight alternate delegates, recently attended the 120th annual meeting of the AMA in Atlantic City, New Jersey, June 20-24.

Illinois presented nine resolutions to the House. Following is the action taken on each:

1. **Expansion of MECO Project**—A request that AMA-ERF be requested to consider financial aid to the SAMA-MECO project was approved.
2. **AMA-ERF Funds for New Medical Schools**—Spokesmen for AMA-ERF assured the Reference Committee studying this resolution that all medical schools, including those newly established, are eligible to receive funds and the House re-endorsed this policy.
3. **AMA Drug Evaluation**—The Reference Committee was informed that the Council on Drugs recognized the difficulty posed by the word "irrational" and had already agreed to avoid this term in the second edition of the book which is scheduled for publication in 1973. The Council did, however, take strong exception to the portion of the resolution which would prohibit the Council from recommending one drug or mixture of drugs over another. The House, therefore, directed that future editions of the publication avoid the use of the word "irrational" and that the Resolution be referred to the AMA Council on Drugs and the Committee responsible for the 1971 AMA Drug Evaluation publication.
4. **Outpatient Surgery**—The House endorsed the concept that outpatient surgery under selected circumstances is a part of good medical practice, but it also accepted the Reference Committee's comment that all such facilities should have immediate access to adequate back-up facilities for hospitalization of the patient if the need arises.
5. **Need for Control of Imbalance Among Different Medical Specialties**—The House adopted the following substitute resolution:

 Resolved, That the subject of the number of residents, their distribution among the residency programs in the various specialties, and the relation of the number of residents in training in the various specialties to the supply of and need for physicians in the various specialties be referred to the Council on Medical Education for its continuing study, and that information concerning these matters be supplied, through appropriate channels to medical students, interns, residents, medical schools and hospitals involved in graduate medical education, and that regular reports on these matters be made to the House of Delegates.
6. **Doctor Draft**—The Reference Committee agreed that physicians should not be discriminated against under the Selective Service laws, but based on testimony before it, the Committee took the position that the doctor draft provisions are an integral part of the Selective Service Act and that the intent of the resolution concerning the supply and utilizations of health personnel in shortage areas is now being carried out. Therefore, the Reference Committee recommended that the resolution be filed (same as accepting for information). The House concurred.
7. **Emergency Health Personnel Act of 1970**—Referred to the Board of Trustees for further study by the AMA legal department and Council on Medical Service for appropriate follow-up.
8. **Community Health Week**—The Reference Committee recommended that de-emphasizing dates and leaving the time of year up to individual medical societies is the best solution to the issue. The resolution was filed with the recommendation that Community Health Week be observed by medical societies at a time of their own choosing.
9. **Implementation of Work Program**—Recommended by the Committee on Health Care of the Poor. (Not originated in the ISMS House.) The following substitute resolution was adopted:

 Resolved, that to initiate programs applicable to its area, state and local medical societies be urged to appoint a Committee on Health Care of the Poor, or assign this function to an appropriate existing committee; and that these committees maintain liaison with the AMA Committee on Health Care of the Poor.

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the presidents page

Physicians + organized medicine = action!

The recently concluded annual meetings of the Illinois State Medical Society and the American Medical Association prove one thing—that the medical profession DOES effectively represent individual physicians.

Both annual meetings initiated lengthy discussion and exchange of opinions on the medical profession's role in relation to the public, governmental health planning and on the practice and life-style of the individual practitioner.

We continue to hear complaints that our organizations fail to reflect the aims, purposes and desires of the individual physician.

This is not true! The positions and policies recently adopted by ISMS and the AMA came only after vigorous discussion, debate, and a majority vote—the essence of true democracy.

Any individual physician, group of physicians, or county medical society, may present ideas or plans to the state medical society. This input is assigned to ISMS Reference Committees for discussion and debate. The individual physician is given every opportunity to convince the Reference Committee of the wisdom and the worth of his proposal. But each physician must be willing to *stand up* and *participate* in the democratic process.

A favorable report by the reference committee is often accepted by the House of Delegates, again after due deliberation, and becomes part of official policy or position of the Society.

Thus, most proposals are initiated at the local level and receive state consideration, except for crucial issues which arise on the spur of the moment. These may require direct action by the ISMS Board of Trustees, House of Delegates, or both.

This same course of events transpires at the national level where most issues are initiated by individual physicians, groups of physicians, or by state societies.

In 1970, there were 214,053 physician-members of the AMA, representing 82% of the office-based practitioners in the nation. The AMA is a federated organization of 50 states and five territorial medical societies, including 1,950 component societies.

County societies elect delegates to their respective state societies which in their turn elect one delegate to the AMA House of Delegates for each thousand (or fraction thereof) state society members. To these are added five delegates from the federal services, 23 from specialty societies, and two ex-officio members from the Student AMA.

When the AMA issues a policy statement it speaks for 214,053 physician-members through its 246-man House of Delegates.

Differences of opinion are inevitable. However, in light of the facts above, it follows that all actions and positions of organized medicine are the result of careful, thoughtful and considered deliberations which reflect the best input of the vast majority of physician-members.

Recently there have been some AMA membership losses and threats of further drop-outs. It is difficult to understand how one can justify termination of membership as a valid course of action because of differing opinions.

Further fragmentation in the medical profession can only result in a decreased power in the voice of medicine—a loss to the dissident physician as well as those who are active in our medical societies.

L. J. Fuerst M.D.

IMJ
Illinois Medical Journal

Toward the rational use of Digoxin

By David J. Greenblatt, M.D./Boston

In the two centuries which have elapsed since the introduction of the digitalis glycosides into clinical use by William Withering, the importance of this class of drugs in the treatment of heart failure has not at all diminished. The derivatives of digitalis have given added years of useful life to many patients whose cardiac output would otherwise have been inadequate to sustain life. Simultaneously, digitalis intoxication has remained one of the most common of iatrogenic diseases.

Withering himself was the first to point out the narrow range between therapeutic and toxic doses of the Foxglove. In the days when relatively impure digitalis preparations such as powdered digitalis leaf were the only forms of the drug available for use, gastrointestinal manifestations of toxicity usually were the first to appear.[1] Careful titration of dosage was necessary to produce therapeutic benefit without the concomitants of anorexia, nausea, vomiting or diarrhea. These adverse gastrointestinal effects, although troublesome, generally preceded the more serious cardiotoxic effects. However, with the recent advent of highly purified synthetic digitalis preparations such as digoxin and digitoxin, dangerous cardiac arrhythmias, manifested as increased irritability and/or defects in conduction,[2,3] may often be the initial presentations of intoxication.[1] Thus, the significance and seriousness of digitalis toxicity have increased as the synthetic preparations have come into wider use. Also of great importance is the frequent simultaneous use of potent diuretics such as the thiazides and most recently furosemide and ethacrynic acid, whose kaliuretic properties may rapidly deplete the total body stores of potassium, further predisposing to digitalis-induced arrhythmias.

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Digoxin is probably the most widely used digitalis preparation at the present time. A recent epidemiologic survey of hospitalized medical patients revealed that 20% of all patients received digoxin during their periods of hospitalization.[4] Eighteen percent of patients treated with digoxin manifested unequivocal signs of intoxication, either gastrointestinal, cardiac or otherwise. Digitalis toxicity was significantly correlated with the finding of hypokalemia and with the concurrent use of furosemide.

The high incidence of intoxication associated with the use of digoxin is only partly explained by the small toxic-to-therapeutic dose ratio of this drug, or by the frequent occurrence of diuretic-induced hypokalemia. Equally important is the fact that our understanding of the human kinetics of digoxin has until recently been scant. The crucial knowledge of how much digoxin constitutes a therapeutic level and how best to achieve and maintain this level has been largely based upon trial-and-error, personal experience, and clinical lore rather than upon a sound understanding of kinetics. Recently, however, a number of clinical studies and theoretical formulations have provided information regarding the pharmacokinetics of digoxin so that a step toward the more rational use of this agent is now possible.[5-7] The purpose of this article is to provide an interpretation of these studies which is useful to the clinician.

Guiding Principle

The forthcoming scheme for the rational use of digoxin is based upon the observation that the cardiotonic effect of digoxin is directly proportional to the quantity of drug present in the myocardium. This fact may seem too obvious to be worthy of mention, but it is not always true that the effect of a drug upon an end-organ is related to the quantity of drug contained in that organ. For digoxin, however, the proportion does hold. Since the myocardial content of digoxin remains approximately thirty times greater than the concentration in blood,[8] the blood level of digoxin is a good index of myocardial content. Serum digoxin levels may be determined by radioimmunoassay. Therapeutic levels are in the range of 1.0 to 2.0 μg/liter, while values greater than 3.0 μg/liter are generally toxic.[9,10] A simple method of digoxin therapy would be to administer the drug in quantities appropriate to maintain blood levels in the therapeutic range, as followed by repeated serum digoxin determinations. Clearly, however, the necessary laboratory facilities are unavailable to most physicians, and the establishment of therapeutic blood levels must be carried out without the convenience of direct measurement.

Just as the myocardial digoxin content depends upon the serum level, so the serum digoxin concentration is directly related to the total quantity of drug within the body. A total body digoxin content of 1.0 to 1.2 mg is therapeutic in most subjects of average size,[6] and probably corresponds to the therapeutic blood levels previously indicated. The objective of therapy, then, is to maintain the body digoxin content in this range. Without the benefit of direct measurement, this can be achieved only with a knowledge of the kinetics of absorption and excretion, and by careful titration of intake balanced by removal.

Kinetics of Absorption

Digoxin has traditionally been administered to adults in tablet form. The gastrointestinal absorption of oral digoxin tablets, however, varies widely and unpredictably both within the same patient and between different patients. As little as 40% of a dose given by tablet may actually be absorbed by the GI tract. Clearly such unknown variations in absorption are unacceptable for oral therapy in which careful titration of intake versus excretion is required. On the other hand, digoxin administered in elixir form is absorbed much more predictably. Eighty-five percent of an oral dose is absorbed by most patients, with a variability of 10% or less.[11,12] A further advantage of digoxin elixir is that doses may be adjusted in increments of .01 mg or less, whereas digoxin tablets cannot be conveniently subdivided below .125 mg. Digoxin elixir is available commercially in concentrations of .05 mg/cc. This form of the drug is recommended for oral therapy. (Subsequent



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discussion will be in terms of this form of administration.)

Parenterally-administered digoxin obviously is not subject to variations in gastrointestinal absorption, so that 100% of an intramuscular or intravenous dose can be considered added to the body store.

Kinetics of Excretion

Digoxin is essentially unmetabolized by the human body. More than 90% of a parenterally-administered dose of tritium-labeled digoxin is eventually excreted unchanged in the urine and feces. It would be expected that hepatic dysfunction would cause very little alteration in the kinetics of digoxin excretion, and this has been confirmed clinically.[13]

The disappearance of digoxin from the body very nearly follows a simple exponential pattern, in which a fixed proportion (k) of the total body digoxin content (D) is excreted daily. Both urinary and fecal losses contribute to the daily excretion, and the relationship is summarized as follows:

(Eq. 1) $Total\ daily\ excretion = K \cdot D = urinary\ loss + fecal\ loss$

Daily losses via the fecal route are relatively fixed and are generally 15% of the body store. Urinary losses vary directly with renal function as measured by the endogenous creatinine clearance (C_{cr}). It has been proposed and confirmed clinically that the following relationship expresses urinary loss as a function of creatinine clearance:

(Eq. 2) $Daily\ urinary\ loss = .002\ C_{cr} \cdot D$

where C_{cr} is given in cc/minute. With this relationship it becomes possible to calculate the value of k as:

(Eq. 3) $k = .15 + .002\ C_{cr}$

so that the total daily loss of digoxin can be written as:

(Eq. 4) $Daily\ excretion = (.15 + .002\ C_{cr}) \cdot D$

Table I shows the relationship between renal function and digoxin survival time in the human body. In an anephric or anuric patient, only 15% of the body digoxin stores are depleted daily, so that the digoxin half-time is 4.25 days; two weeks are required for 90% of body stores to be depleted. On the other hand, in a subject with normal renal function the digoxin half-time is approximately 1.5 days, and only five days are required for 90% of body stores to be depleted. Under normal circumstances 35 to 40% of total body digoxin is excreted daily. From Table I it is clear that intoxication is of greater concern in patients with poor renal function in whom a much longer time is required for digoxin excretion.

Table I
Digoxin Survival As A Function of Creatinine Clearance

C_{cr} (in cc/min)	k (fraction of total body digoxin excreted daily)	Digoxin Half-time (days)	Time for 90% disappearance (days)
0	.15	4.25	14.1
20	.19	3.28	10.9
40	.23	2.66	8.85
60	.27	2.22	7.48
80	.31	1.87	6.20
90	.33	1.73	5.75
100	.35	1.60	5.34
110	.37	1.50	4.98
120	.39	1.40	4.66
140	.43	1.23	4.09

Loading and Maintenance

With knowledge of the relationship of digoxin excretion to renal function, as expressed by the coefficient k, it is possible to calculate the daily dose necessary to maintain a given body digoxin store. A patient who enters day one of maintenance therapy having received a loading dose (L) has a total body digoxin store at the end of day one given by:

(Eq. 5) $D_1 = (1 - k)(L + M)$,

where M is the daily maintenance dose given at the beginning of each day of therapy. Since $k \cdot D_1$ of the total body store is excreted in day two, the digoxin store remaining after day two is:

(Eq. 6) $D_2 = (1 - k) \cdot D_1 + (1 - k) \cdot M$
$= L \cdot (1 - k)^2 + M \cdot [1 - k + (1 - k)^2]$

Repeating this pattern, the body store after the nth day of therapy is:

(Eq. 7) $D_n = L \cdot (1 - k)^n + M \cdot \sum_{j=1}^{n} (1 - k)^j$

The digoxin content at equilibrium (D) after an "infinite" number of therapy days is given by the mathematical limit of the expression for D_n as n approaches infinity. The first term in this expression, involving L, is zero since $(1 - k)$ is a number less than one. The second term is the sum of a geometric series, which is a well-known mathematical result. The value of D is then:

(Eq. 8) $D = \lim_{n \to \infty} D_n = M \cdot (1/k - 1)$

This value is reached at the *end* of each day of therapy, assuming M is administered as a single daily dose. Just *after* M is administered on the next day of therapy, the body store is increased by this amount, and is given by $M \cdot (1/k - 1) + M = M/k$. Throughout the day, D declines from a value of M/k to $M \cdot (1/k - 1)$, owing to urinary and fecal excretion. This variation may often be unacceptably large. A patient with a creatinine clearance of 100 cc/min. maintained on .50 mg of digoxin administered in a single daily dose (assuming 100% absorption) has a total body store of 1.43 mg just *after* the maintenance dose is given, and 0.93 mg just *before* the maintenance dose. The patient may actually manifest intoxication in the period after the maintenance dose, and be inadequately digitalized in the period before the next maintenance dose. Thus the single daily dose maintenance schedule for digoxin therapy is probably not an appropriate one.

It can be shown that if the same dose from the above case were divided and given twice daily, the body digoxin level would vary from 1.43 mg to 1.18 mg. If given in three doses spaced eight hours apart, the values vary from 1.43 mg. to 1.26 mg. Obviously the fluctuation in body digoxin stores becomes smaller as the daily maintenance dose is subdivided and given more often. It is recommended that a "q8h" maintenance schedule is optimal, causing minimum inconvenience to the patient and resulting in fluctuations in body digoxin levels which are acceptable. The patient may take his medication upon arising, again at 3 p.m. and upon retiring at night, with resulting fluctuations of only one-third of the total daily maintenance. Under this schedule the relation between total body digoxin stores and daily maintenance dosage at all times is closely approximated by the expression:

(Eq. 9) $D = M/k$.

In clinical practice, adjustment must be made for the fact that only 85% of a given oral dose of digoxin elixir is absorbed from the GI tract, so that maintenance dosages determined from Equation 9 should be multiplied by $1.00/.85 = 1.18$ to account for the 15% of each dose which is unabsorbed.

A large number of patients will respond optimally to digoxin when total body stores are in the range of 1.0 to 1.2 mg., and it is recommended that this range be aimed for at the initiation of therapy. Slightly higher levels may be required for the control of ventricular rate in atrial fibrillation, and adjustments may be made if the recommended body store of 1.0 to 1.2 mg proves to be inadequate or excessive. Few patients require more than 1.4 to 1.5 mg. of body digoxin, and few are adequately digitalized with less than .7 mg. The daily doses required to maintain various body digoxin stores at different values of endogenous creatinine clearance are shown in Table II. Oral administration of digoxin elixir is assumed, and the given doses have been corrected to account for 85% absorption. Again, it is recommended that the indicated daily dose be divided in thirds and administered every eight hours.

Renal function is clearly an important determinant of the proper digoxin dosage level.[14] While the endogenous creatinine clearance is generally considered to be an accurate indicator of glomerular filtration rate, the calculation of C_{cr} requires a 24-hour collection of urine, and thus is not always a conveniently determined parameter. In younger patients, the creatinine clearance in cc/min. may be approximated by $C_{cr} = 110/P_{cr}$, where P_{cr} is the plasma or serum creatinine in mg/100 cc. In elderly patients, however, this approximation may dangerously overestimate the creatinine clearance. Renal function is known to deteriorate with age, but this may occur without significant change in the serum creatinine value, since there is often a concomitant decrease in muscle mass with age. Thus, a 75-year-old patient with a serum creatinine of 1.1 mg/100 cc. may have a creatinine clearance of only 50 cc/min. In one recent study,[15] digoxin kinetics in "young" and "elderly" patients were compared. While serum creatinine levels did not significantly differ between the two groups, creatinine clearances were markedly smaller, and

Table II

Daily Oral Maintenance Doses of Digoxin Elixir*

Creatinine Clearance in cc/min	Total body digoxin content at equilibrium (milligrams)								
	0.7	0.8	0.9	1.0	1.05	1.10	1.15	1.20	1.30
0	.125	.140	.160	.180	.185	.195	.200	.210	.230
20	.155	.180	.200	.220	.235	.250	.260	.270	.290
40	.190	.215	.245	.270	.285	.300	.310	.325	.350
60	.220	.255	.285	.320	.335	.350	.365	.380	.415
80	.255	.290	.330	.365	.385	.400	.420	.440	.475
90	.270	.310	.350	.390	.405	.425	.445	.465	.505
100	.290	.330	.370	.410	.430	.455	.475	.495	.535
110	.305	.350	.390	.435	.455	.480	.500	.520	.565
120	.320	.365	.415	.460	.480	.505	.530	.550	.600
140	.355	.405	.455	.505	.530	.555	.580	.605	.655

*Values given in milligrams and adjusted to allow for 85% absorption

digoxin half-life values markedly larger in the elderly patients. These results may explain the clinical impression that older patients are more "sensitive" to digitalis, or more "prone to toxicity." There is probably no age-dependent alteration in myocardial sensitivity, but only a decreased clearance of digitalis due to deteriorating renal function which is not adequately accounted for in dosage schedules. Only a determination of C_{cr} can adequately document such changes, and a measurement of this parameter should be carried out whenever possible before initiating digoxin therapy in patients of all ages, and particularly with those in the geriatric group.

Equation 9 shows that the body content of digoxin at equilibrium does not depend upon the loading dose.[16] A fixed percentage of the initial loading dose is excreted daily, so that at "equilibrium" (after many days of therapy) this initial dose has been completely eliminated, and the total body digoxin store depends only upon the maintenance dose according to Equation 9. The loading dose only allows equilibrium to be attained more rapidly. This may be necessary in urgent situations such as acute pulmonary edema when full digitalization must be rapidly attained using large parenteral doses. In most situations, however, rapid digitalization is not necessary and loading doses should be avoided, since a given patient's optimal digoxin content can only be estimated, and an overshoot of this value with a loading dose may result in acute toxicity. Elective digitalization may be carried out simply by initiating therapy with the proper maintenance dose, aiming for an equilibrium digoxin content of 1.0 to 1.2 mg. The patient's response may be followed clinically, and adjustments in dosage may be made as necessary. Equilibrium is attained in an exponential fashion, and the time required for digoxin stores to reach 90% of their final values by this method can be shown to be identical to the times given for 90% excretion as shown in the last column of Table I. In patients with normal renal function, equilibrium is attained within one week of the onset of therapy. In most cases this is an acceptable delay.

Application

The following case reports illustrate how these principles may be applied in clinical practice.

Case 1

A 47-year-old man, who ten weeks earlier had suffered an uncomplicated but extensive lateral wall myocardial infarction, visits his physician with a one week history of mild exertional dyspnea without chest pain. Physical examination was unremarkable except for fine rales at both lung bases, a finding not present on previous examinations. No change in body weight was noted. An electrocardiogram was unchanged from previous tracings.

A blood sample for serum creatinine was drawn at that time, and the patient was instructed to collect and return a 24-hour urine specimen. Chlorothiazide, 500 mg, was prescribed to be taken every other morning, and he was asked to return in ten days.

Analysis of the urine specimen two days later revealed 1.7 gm of creatinine in a total volume of 1600 cc. The serum creatinine was 1.1 mg/100 cc., giving an endogenous creatinine clearance of 154 liters/day or 107 cc/min. By telephone, the patient was instructed to begin maintenance therapy with digoxin elixir, .42 mg daily (2.8 cc in orange juice every eight hours).

On a follow-up visit, the patient reported symptomatic improvement, and basilar rales were no longer heard on physical examination of the lungs. Electrocardiogram revealed ST-segment coving but no arrhythmias or conduction disturbances.

Case 2

A 73-year-old woman was brought to the emergency room at 2 a.m. with an episode of acute dyspnea. She had a history of two previous myocardial infarctions and was maintained on the outside on a diuretic, potassium supplement, and a digitalis preparation. The patient's family indicated that she had failed to take her medications in the past ten days and also had failed to adhere to her salt-restricted dietary regimen.

On physical examination, the patient was in acute respiratory distress with tachypnea and cyanosis of the lips. She was diaphoretic and had a pulse rate of 130 beats per minute, but was not hypotensive. Neck veins were distended, and wet rales were heard through both lung fields. The liver was tender to palpation and there was trace pitting edema of both ankles. Electrocardiogram revealed sinus tachycardia with two to three premature ventricular contractions per minute.

Morphine sulfate (5 mg), furosemide (40 mg), and digoxin (0.5 mg) were given intravenously, and oxygen was administered by nasal cannula. Further doses of digoxin (0.125 to 0.25 mg) were given intramuscularly at intervals of three to four hours.

The patient responded with a brisk diuresis, and her status improved rapidly. Twelve hours after admission she was comfortable and had a pulse rate of ninety beats per minute with no extrasystoles. Bibasilar rales were still heard. 1.125 mg of digoxin had been administered over this time, and maintenance therapy was begun with digoxin elixir (2.5 cc every eight hours). Chlorothiazide (500 mg twice a day) and potassium supplements were administered as well. A determination of C_{cr} revealed a clearance of 65 cc/min, and the digoxin maintenance dose was accordingly revised to 2.2 cc every eight hours (.36 mg per day).

The patient continued to improve until the sixth hospital day when she again became dyspneic. Electrocardiogram showed ventricular bigeminy. An emergency serum potassium determination revealed a level of 3.1 mEq/liter. Digoxin was withheld, oxygen was administered, and 40 mEq of potassium chloride were given intravenously over five hours. Subsequently, oral potassium supplements were increased, and maintenance digoxin was reduced to 2.05 cc every eight hours (.33 mg daily). The patient was discharged on this regimen after 12 days of hospitalization during which time serial electrocardiograms and serum enzyme determinations did not provide evidence for new myocardial infarction.

Limitations

The described guidelines for digoxin therapy are based upon average values of physiologic parameters as determined by a study of a large number of subjects. In most patients, the kinetics of absorption and excretion, as well as the sensitivity to digitalis, will fall close enough to the "average" so that these guidelines are reasonable ones. In some patients, however, significant deviations will occur. Some, for example, may absorb only 40% of a given dose of digoxin elixir; some may manifest toxicity at a total body store of 0.8 mg; and some may be inadequately digitalized with a total digoxin content of 1.5 mg. Such physiologic variations are, of course, largely unpredictable, and may thwart attempts to administer digoxin by rationally determined guidelines.

On the other hand, there are certain conditions under which the sensitivity to digitalis is altered in a reasonably predictable way. Hypoxia, hypokalemia, hypercalcemia, and acidosis are known to predispose myocardial tissue to the cardiotoxic effects of digitalis. Recognition of these conditions allows the physician to adjust digoxin dosage in the proper direction, although the magnitude of the adjustment can only be determined empirically. Similarly, the concurrent administration of reserpine is thought to increase the sensitivity to digitalis.[17,18] Patients formerly in atrial fibrillation, who have converted to sinus rhythm, also generally require a reduction of digitalis dosage.

Studies of digoxin metabolism in patients with thyroid disease have shown that the kinetics of digoxin absorption and excretion are unaltered by thyroid dysfunction.[19] Nevertheless, a given dose of digoxin results in unexpectedly high blood levels in patients with hypothyroidism, and in unexpectedly low levels in hyperthyroid patients, when compared with levels obtained after equivalent doses in euthyroid individuals.[19] The mechanism of these alterations in blood digoxin levels has not as yet been completely elucidated, but such findings may in part account for the clinically observed phenomena of digitalis "sensitivity" in myxedema, and digitalis "resistance" in thyrotoxicosis. Thyroid disease is thus another condition in which alteration in digoxin dosage is required.

Digitalis is simultaneously one of the most useful and one of the most dangerous agents in the physician's pharmacologic armamentarium. The incidence of digitalis intoxication is alarmingly high. While the indicated recommendations for the use of digoxin are not uniformly applicable to all patients, it is probable that the implementation of these guidelines will allow a larger number of individuals to experience therapeutic benefit without toxicity. ◄

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World's largest debtor

The $371.4 billion the Federal Government owed at the start of 1970 exceeded by more than $67 billion the public debt of all other nations combined.

the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

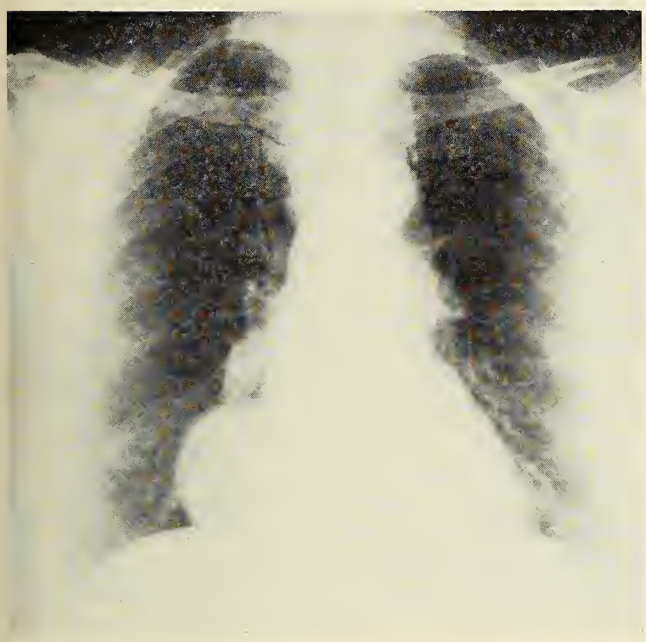


Fig. 1



Fig. 2

This 52-year-old asymptomatic female was admitted to the hospital following an abnormal, routine chest X-ray. What's your diagnosis?

1. Aneurysm of the descending aorta
2. Neurofibroma
3. Pericardial cyst
4. Epiphrenic esophageal diverticula
5. Hernia through the foramen bochdalek

(Answer on page 168)



surgical grand rounds

Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial, and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of June 6, 1970.

Edited by John M. Beal, M.D.

Long term fate of arterial homograft

Case Report:

Dr. Thomas Kornmesser: A 74-year-old, white male entered V.A. Research Hospital with the complaint of a non-tender pulsatile mass on the medial aspect of his right thigh, present for approximately two years. In 1956, the patient was subjected to a right femoro-popliteal bypass for arteriosclerotic occlusion, at which time a homograft was used. The patient had been well until the pulsatile mass was noted. He denied claudication but did note coolness and paresthesia of the right foot. The past medical history was noncontributory.

Pertinent physical findings were limited to the lower extremities. A 7x10 cm. non-tender pulsatile mass was present in the medial aspect of the right thigh just above the knee. The pulses on the left lower extremity were within normal limits; on the right, only the femoral and popliteal pulses were felt and the popliteal was diminished.

Laboratory data were within normal limits. A femoral arteriogram was performed.

Dr. Abram Cannon: The femoral arteriogram demonstrates a large aneurysm which appears to arise from the graft (Figure 1). The anastomosis between the graft and distal portion of the superficial femoral artery seems to be about two inches below the aneurysm.

Dr. Julius Conn, Jr.: The use of arterial homografts seems to have started vascular surgery on a never-ending circle. Autogenous vein grafts were first suggested as an arterial substitute in 1898. In 1910, the first arterial homograft was utilized; unfortunately, it failed because of technical problems. Prior to that, in 1902, Carrel and Guthrie had described most of the techniques which are currently used in vascular surgery, although there was almost a 50 year hiatus between the time they developed the techniques and the time they were first widely used. In 1923, Leriche, after describing his syndrome, suggested that the distal aorta and iliac vessels

could be bypassed with a graft of some sort. He never followed through with this suggestion so it was years later before bypass grafting was successfully carried out. In 1949-50, Dr. Gross and then Dr. Hufnagel again rediscovered aortic homografts as vascular substitutes. They then completed the first circle in the history of vascular grafts. With the use of aortic homografts, they successfully bypassed the thoracic aorta, performed Blalock-Taussig anastomoses using arterial homografts, and later utilized these grafts to revascularize the aortoiliac and the femoropopliteal circulation.

In time, the demand for homografts outstripped the supply. Harvesting arterial homografts produced legal and economic problems in addition to the technical difficulties in processing and storage. Sterilization and storage techniques were extremely important and strongly influenced long term results. With early grafts, the grafts were used fresh after a short storage in saline solutions with antibiotics added. Later, the grafts were irradiated, freeze dried, or sterilized with ethylene oxide. Interestingly enough is the fact that the long-term survival of many of the grafts is directly related to the storage technique. Irradiated grafts did poorly; fresh grafts did best; those that were freeze dried were somewhere in the middle.

Another difference observed is that large grafts, such as those placed in the thoracic aorta and some which were used in the abdominal aorta, have lasted up to 20 years. Some of these are still functioning with only minimal calcifications in the wall and no evidence of aneurysm formation. A theory that seems to permeate the literature is that large grafts have a great deal of elastic tissue in the wall and a minimal amount of muscle tissue, whereas in small grafts, just the opposite holds true. Apparently the elastic tissue remains viable longer and is less antigenic than smooth muscle. Also, the larger grafts are better supported and less mobile.

After five years, approximately 77% of the aortic homografts were patent. At ten years, only 38% remained open. In the femoropopliteal area, 36% were functional after five years and at ten years, only three per cent were patent. Today's patient, then, is in a very select group. At the five year follow-up, approximately 25% of femoral homografts have multiple aneurysms such as seen on our patient. After six to ten years, 100% of the homografts in the legs develop aneurysms. This man, therefore, has followed the natural history of small grafts in the leg.

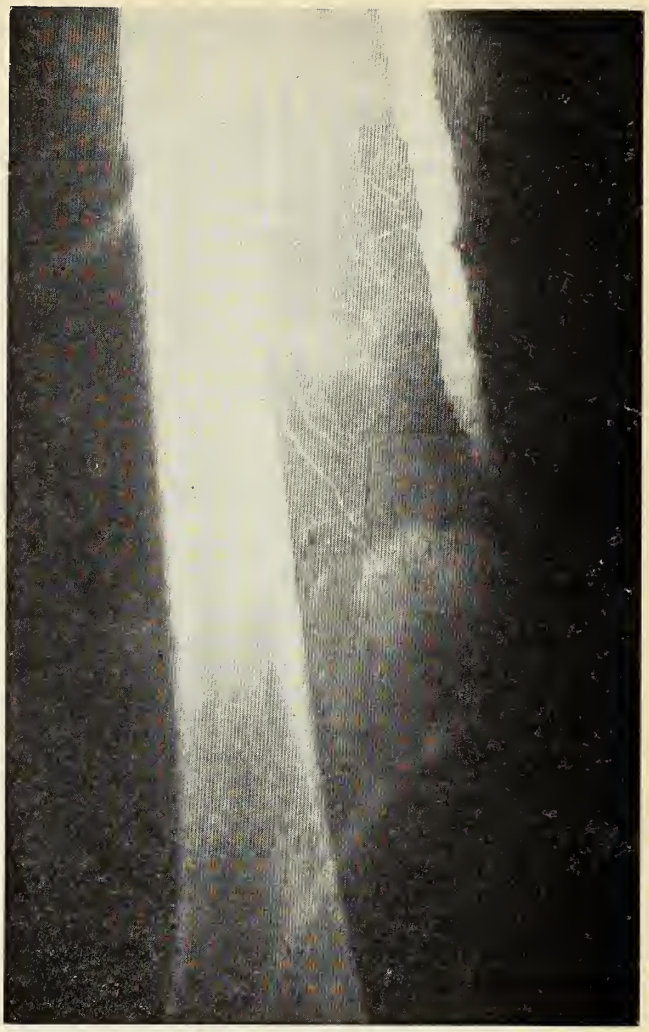


Fig. 1. Femoral arteriogram demonstrates a large aneurysm which seems to arise from the arterial graft.

Other complications of homografts seen included early hemorrhage. This site of leakage was usually at the site of branches which had either been inadequately tied or else had degenerated. Some of the grafts split, probably due to cracking when they were frozen.

The next step around the circle in vascular surgery, following the use of homografts, was the use of synthetic grafts starting with nylon, going through the various synthetics, to Dacron which is presently used. In the lower extremities, autogenous vein grafts were rediscovered to complete the circle which began in 1898. Homologous veins were tried and discarded, and are currently being tried again with some degree of success. Years ago, heterologous arterial grafts were used and once again we've come full circle in that bovine carotid heterografts, which are

enzymatically debrided, leaving a collagen tube, and are undergoing clinical trial. The articles written about the use of heterografts point out that the vein graft is still the first choice in the lower extremity but several groups now prefer to use a bovine heterograft in the lower extremity, rather than a Dacron graft. Thus, we keep going around in circles and re-discovering vascular grafts which in some cases were used almost a hundred years ago.

Dr. C. Rollins Hanlon: I recall an old fellow who had a large pulsating hematoma in midthigh, which a shrewd anesthesiologist kept the referring doctor from incising as an abscess. We evacuated it and bridged the defect with a homograft that originally lay in a large cavity without nutrition or mechanical support for the graft. Within a period of three weeks, he had several major hemorrhages from points along the graft. Eventually, we were able to tie off the vessel and save his extremity after rerouting the graft by transposing it into what was left of the medial thigh muscles. Even with support of surrounding tissues, that homograft had multiple areas of weakness which gave way serially at weekly intervals.

This demonstrated that one may cause mechanical damage to the graft in harvesting it. At one hospital, a former resident demonstrated how easy it is to damage a vessel when removing it at autopsy or processing it thereafter, whether by freezing, manipulation or tying off branches. These simple mechanical damages at the point of origin of a branch or at an area of stretching might appear trivial but their significance could be demonstrated by hydrostatic studies, by careful microscopic study or by clinical malfunction.

Dr. John Beal: This man has an aneurysm and we have discussed the historical background and principles of treatment of aneurysms. What should be done with this patient now?

Dr. John Bergan: The aneurysm should be removed and circulation restored by the best means available, which might consist of a graft from the saphenous vein from that extremity, if it's there, from the other extremity if it's not, from the cephalic vein if that's available, and then as a last choice, a Dacron graft.

Dr. Conn, Jr.: He has a large greater saphenous vein palpable in his leg so the current plan is to remove the homograft and replace it with the saphenous vein using the subsartorial route, where the graft will be better supported and subject to less stress.

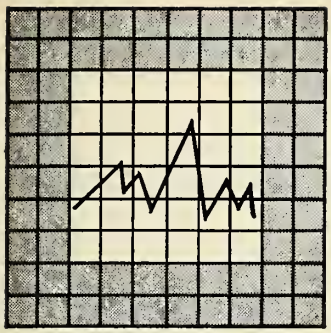
ECG Center installs new computer For heart disease treatment and research

The installation of a new computer facility in Northwestern University Medical School's Reingold Electrocardiographic Center will provide virtually immediate interpretation of electrocardiograms. Previously, 24 to 48 hours were required for the participating hospitals to receive interpreted records.

The Reingold ECG Center, an example of shared services in the Northwestern University-McGaw Medical Center, was organized in 1964 to provide complete electrocardiographic services on a 24-hour-a-day basis. Electrocardiograms are transmitted by common carrier telephone lines from Chicago Wesley Memorial and Passavant Memorial hospitals, the Rehabilitation Institute of Chicago, and the Northwestern Medical School clinics to the Center.

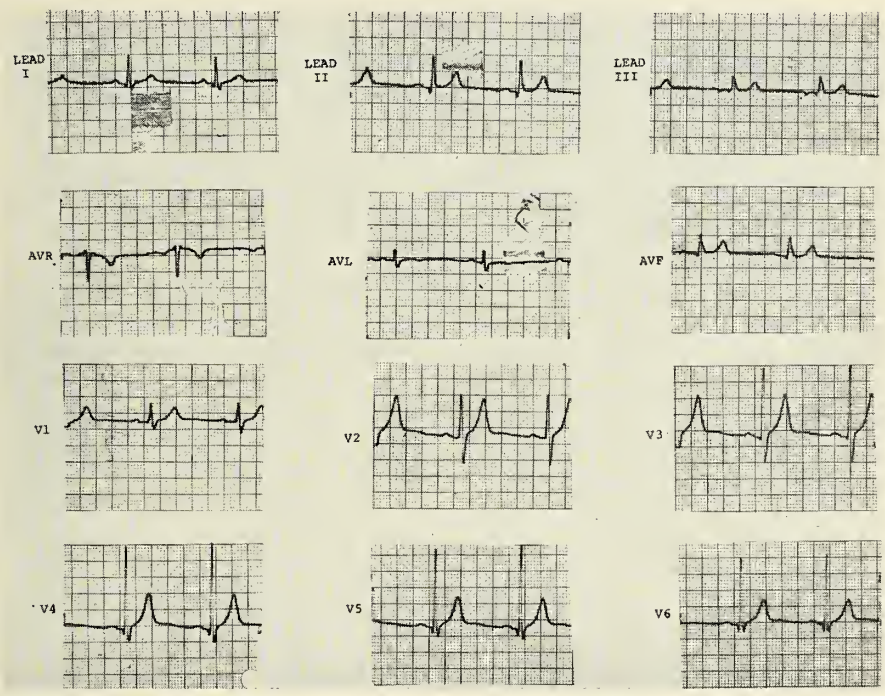
The ECG Center is also devoted to basic and clinical research in the broad field of electrocardiology, including cardiac electrophysiology. Particular emphasis is placed on studies designed to find the causes of disturbances of cardiac rate and rhythm in patients with heart disease, the modes of action of drugs used to treat these disturbances, and on techniques for diagnostic and therapeutic use in patients.

Automation of data acquisition, processing and analysis accomplished by the new computer facilitates both teaching and research in the Center. More than 125,000 electrocardiograms, recording over 6,000,000 heartbeats, are currently on file in the Center.



ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D.
and Patrick Scanlon, M.D./Section of Cardiology,
Department of Medicine
Loyola University Stritch School of Medicine



A 61-year-old man was admitted for evaluation of increasing chest pain with exertion. He gave a history of a "heart attack" the previous year "which did not show-up on the electrocardiogram." Physical examination was normal except for S_4 at the apex.

QUESTION (One or more of the following statements may be correct):
The electrocardiogram showed:

A. Right ventricular hypertrophy
B. True posterior myocardial infarction, old
C. Right bundle branch block (RBBB), complete
D. Pre-excitation syndrome (Wolf-Parkinson-White syndrome)
E. Normal tracing

(Answer on page 168)

Massasauga rattlesnak

By Stuart M. Poticha, M.D./Chicago

Although four species of poisonous snakes are found in Illinois (American copperhead, *Agkistrodon contortrix,* cottonmouth, *Agkistrodon piscivorus,* timber rattlesnake, *Crotalus horridus,* and Massasauga rattlesnake, *Sistrurus catenatus)* only the latter inhabits the immediate Chicago area. These snakes are not aggressive and bites rarely occur. Recently, however, two children playing in the Potowatomie Woods of the forest preserves near Dam 1 on the Des Plaines River were bitten by Massasauga rattlers. Because these snakes have been known to inflict fatal injuries in man, these case histories and the current management of rattlesnake bite are reviewed.

Case I:

A 17-year-old white female was admitted to the emergency room of Holy Family Hospital five hours after being bitten on the left thumb by a small snake. The patient stated that, while attempting to pick up a small snake she discovered in the forest preserves near Dam 1, she was bitten. The snake escaped but was described as being about 12 inches long and brown in color. The patient did not hear a rattle nor notice the snake's tail. Within five minutes, the left thumb and hand became painful and swollen. The swelling gradually increased and within two hours involved the entire hand and distal one-half of the forearm. Three hours after being bitten, the patient developed nausea and mild, cramping abdominal pain.

Physical examination revealed a healthy 17-year-old, white female in no apparent distress. The pulse rate was 84 beats per minute, the blood pressure was 110/80 mmHg., and the oral temperature was 99.6°. Positive physical findings were limited to the left upper extremity. Two 1 mm. lacerations 1 cm. apart were present on the dorsal aspect of the left thumb at the interphalangeal joint. The entire thumb was markedly swollen and exquisitely tender. The patient was unable to flex the thumb at either joint. The left upper extremity was swollen to the shoulder with pitting edema of the dorsum of the hand. The left epitrochlear node was not palpable but several enlarged discrete tender nodes were palpated in the left axilla.

An intravenous infusion of normal saline with 500 mgm. of polycillin was begun in the right arm. A skin test for hypersensitivity to horse serum was negative and the patient was given one ampule (10 cc.) of Antivenin (Crotalide) Polyvalent intramuscularly, 5 cc. in each buttock. The patient had been previously immunized against tetanus and was given 0.5 cc. of tetanus toxoid subcutaneously. She was then transferred by ambulance to Passavant Memorial Hospital.

The physical findings were unchanged when the patient arrived at Passavant. Laboratory tests performed on admission revealed 12.9 gm. of hemoglobin with an hematocrit of 40%. The white blood count was 9,050 with a normal differential. Urinalysis revealed 3-5 red blood cells per high power field but was otherwise normal. The coagulation time was 13 minutes. The pro-

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ite in the Chicago area

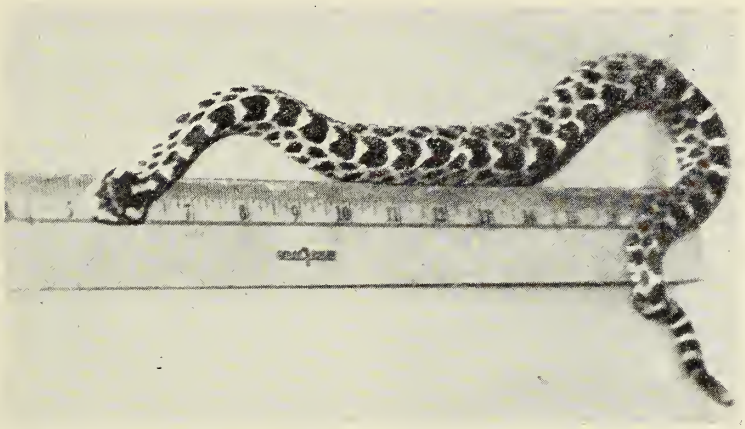


Fig. 1: Massasauga rattlesnake, *Sistrurus catenatus*

thrombin time was 11.6 seconds with a control of 9.8 seconds. The partial thromboplastin time was 40 seconds (normal value less than 40 seconds). Blood urea nitrogen and serum electrolytes were normal.

A central venous catheter was inserted and the patient was typed and cross-matched for three units of blood. Using sterile technique, each fang mark was infiltrated with 1% xylocaine and incised a distance of 1 cm. These wounds were irrigated with 1,000 cc. of normal saline. A large pressure dressing and splint were applied to the left hand and forearm. Ice packs were placed over the dressing and the arm elevated. A Foley catheter was inserted. Antibiotics consisting of intravenous aqueous penicillin, five million units every six hours and intramuscular streptomycin, 0.5 gm. every 12 hours were given daily for three days.

The patient was transferred to Intensive Care, where her vital signs and urinary output were carefully recorded. Six hours after admission, the patient's temperature was 101.6° orally. Her pulse was 100 beats/minute with a blood pressure of 114/70 mmHg. The respirations were 20/minute and the central venous pressure, 4 cm. H_2O. The blood count was repeated and revealed a hemoglobin of 12.9 gm. with a hematocrit of 38%. The white blood count was 19,400 with a shift to the left.

The patient's oral temperature continued to rise to a high of 103.4° recorded 24 hours after injury. This gradually returned to 98.6° over the next eight hours and remained normal until discharge. The admission laboratory tests were repeated every 24 hours. The hematocrit fell to 35%, where it stabilized. The white blood count returned to 5,000 48 hours after injury and remained unchanged until discharge. The prothrombin time was 15.9 seconds with a control of 9.8 seconds 24 hours after injury, but returned to a normal value by the fourth hospital

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Rattlesnake bite

day. The other laboratory tests remained within normal limits throughout the patient's hospital stay.

The left arm was redressed daily. The edema gradually subsided and was replaced with ecchymosis which extended to the shoulder. The patient was discharged in good condition with her hand and forearm wrapped with an elastic bandage six days after her injury.

Case II:

A 10-year-old, white male was admitted to the emergency room of Holy Family Hospital one hour after being bitten on the left long finger by a small snake. The boy stated that, while playing in the forest preserves near Dam 1, he chased and caught a small snake. When he attempted to pick it up, he was bitten. The 18-inch-long snake was brown in color but was not further identified. Within a few minutes after injury, the left hand became swollen and painful and the patient was brought to the hospital.

Physical examination revealed a healthy 10-year-old, white male in no apparent distress. The pulse rate was 100 beats per minute, the blood pressure 100/70 mmHg and the oral temperature was 98.6°. Positive physical findings were limited to the left upper extremity. Two 1 mm. lacerations were present on the dorsal aspect of the proximal interphalangeal joint of the left long finger. The left hand was markedly swollen to the wrist with pitting edema of the dorsum. The patient was unable to flex the long finger. The left epitrochlear and axillary nodes were not palpable.

An intravenous infusion of normal saline was begun in the right arm. A skin test for hypersensitivity to horse serum was negative and the patient was given one ampule (10 cc.) of Antivenin (Crotalide) Polyvalent intravenously in 80 cc. of normal saline. Using sterile technique, the fang wounds were infiltrated with 1% xylocaine and incised a distance of 1 cm. The wounds were irrigated with 1,000 cc. of normal saline. A pressure dressing and splint were applied to the left hand and forearm. Ice packs were placed over the dressings and the arm was elevated. The patient was given 0.5 cc. of tetanus toxoid subcutaneously. Antibiotics, consisting of intravenous aqueous penicillin, five million units every six hours and intramuscular streptomycin, 0.25 gm. every 12 hours, were given daily for three days.

Laboratory tests performed on admission revealed 13 gm. of hemoglobin with a hematocrit of 38%. The white blood count was 6,700 with a normal differential count. Urinalysis, blood urea nitrogen, platelet count, bleeding time, coagulation time, prothrombin time and partial thromboplastin time were all within normal limits.

The patient was typed and crossmatched for three units of blood, and transferred to Intensive Care. The following day, the swelling of the left upper extremity had increased and the patient was given 5 cc. of Antivenin intramuscularly in the left arm and 5 cc. intramuscularly in the right buttock. The admission laboratory tests were repeated daily and remained within normal limits. The edema of the left arm gradually subsided. Ecchymosis never developed and the patient was discharged in good condition five days after injury.

The Massasauga rattlesnake belongs to the family *Crotalidae,* which includes all of the poisonous snakes in North America with the exception of the coral snakes (*Elapidae*). Members of this family are characterized by a deep hollow (loreal pit) between the eye and nostril, hence the name pit viper. The genus *sistrurus,* or pigmy rattlesnake, contains three species of which only the Massasauga is capable of inflicting a fatal bite in man.

The Massasauga is distributed throughout the Great Lakes region, usually inhabiting bogs or marshes. These snakes are secretive and nonaggressive, usually preferring to hide or escape when encountered.

The snake is ground color, gray, tan or buff, with rows of dark spots along its back (Fig. 1). Adults are occasionally solid black and average 18 to 28 inches in length with a small, well developed rattle at the tail.[1] The rattle can be easily torn off but when present clearly identifies the snake as poisonous.

The poison apparatus consists of a gland located behind each eye and connected to the fangs by a duct. The snake is able to contract the venom gland, thereby controlling the amount of venom injected. The surprised snake may inject no venom or only a small percentage, whereas the fully aroused and angered snake will inject a much larger amount of venom. Most

snakes inject between 25 and 75% of their venom.[2]

The venom of rattlesnakes is a complex mixture of proteins, many of which have potent enzymatic actions. Although snake venoms have been divided into neurotoxins, hemotoxins and cardiotoxins, such division is arbitrary, for most snake venom contains varying amounts of all three toxins. The venom of the Massasauga rattlesnake is primarily hemotoxic and has the following effects:

1) Hemolysis of red blood cells resulting in anemia, hemoglobinemia and hemoglobinuria.
2) Defects in coagulation resulting in prolonged bleeding time, coagulation time and prothrombin time.
3) Lysis of capillary membranes in the area of the bite, resulting in swelling, local hemorrhage and subsequent tissue necrosis.

With severe envenomization, systemic lysis of capillaries occurs leading to melena, hematuria, and cerebral microhemorrhages.[1,2] As in the two cases presented here, severe systemic effects are rarely encountered.

The diagnosis of poisonous snake bite is greatly facilitated when the snake can be positively identified. When the patient is unable to identify the snake, the diagnosis of envenomization must be made on clinical grounds. The patient will present with one or two deep fang marks on the bitten part. From three minutes to one hour after the bite is inflicted, the patient develops local swelling, edema and pain. This may progress over several hours to involve the entire extremity. Regional lymphadenopathy may occur within four hours. With severe envenomization, the bitten area becomes ecchymotic and vessicles may occur. This will eventually result in tissue necrosis. Systemic symptoms are rare but, when present, include headache, lightheadedness, cramping abdominal pain, nausea and vomiting.[1]

The management of poisonous snake bite includes first aid administered in the field, and definitive care in the hospital. In the Chicago area the following first aid measures should be taken:
1) Apply a tourniquet six-inches and preferably at least one joint above the bite. The tourniquet should be tight enough to occlude the venous return without interfering with arterial inflow. It should not be released periodically as continued removal and reapplication has been shown to pump venom into the systemic circulation.[3]
2) If possible, capture and kill the offending snake and bring it with the patient for identification.
3) Splint the bitten extremity and bring the patient to the nearest hospital emergency room.

In the Chicago area, incision and suction should not be performed in the field. These measures should only be undertaken in the hospital, by a physician using sterile technique.

The main therapeutic measures in treating venomous snake bite are antivenin, antibiotics and antitetanus prophylaxis. Ancillary measures such as surgical treatment of the wound, application of cold and the use of corticosteroids remain controversial.[2-7] The treatment protocol outlined below has been prepared by the Northwestern University Medical School Department of Surgery in conjunction with the Lincoln Park Zoological Garden and the Chicago Zoological Society, Brookfield, Illinois, and is based on the most current information available on the management of venomous snake bites. This treatment should be used to manage Massasauga rattlesnake bite as well as bites from other members of the *Crotalid* family.

Poisonous snakes occasionally bite without injecting venom. If envenomization has definitely occurred as evidenced by marked swelling, edema and pain at the site of injury, proceed with the following steps immediately:
1) Place a rubber tourniquet 6 inches and preferably one joint above the site of the bite, and note the time.
2) Check respirations. The venom of these snakes contains minute amounts of neurotoxins which may cause respiratory distress if large amounts of venom are injected.
 a. If the patient is in respiratory distress, assist respirations with ambu bag and oxygen. If respirations stop or are ineffective, the patient must be intubated and connected to a respirator.
 b. If the patient is not in respiratory distress, move on to Step 3.
3) Perform a venipuncture in an unaffected extremity and insert a central venous catheter. Draw blood for the following tests:

 a. Type and crossmatch for three units of whole blood
 b. Complete blood count
 c. Platelet count
 d. Coagulation time
 e. Prothrombin time
 f. Blood urea nitrogen
 g. Serum electrolytes

Rattlesnake bite

An intravenous infusion of Ringer's lactate with 300 mgm. of hydrocortisone should be started. Inject an additional 100 mgm. of hydrocortisone directly into the vein.

4) Using sterile technique, cleanse the skin and infiltrate the area of the bite with 1% xylocaine.

A. If the bite is on the face, neck, hand or foot, make a skin incision 1 cm. in length over the fang mark. A snake fang is curved. If possible, determine the direction of the bite and make the incision parallel to the line of strike. Gently spread the deep tissues down to the base of the fang tract with a curved hemostat. Using the rubber suction cup, suck the wound for 30 minutes and then irrigate with 1,000 cc. of normal saline.

B. If the bite is on the torso or the extremities above the hand or foot, excise an elipse of skin and subcutaneous tissue 4 cm. around the fang marks. Muscle, tendon, nerves and blood vessels should not be excised. Irrigate the wound with 1,000 cc. of normal saline. The wound should be left open for five days, following which delayed primary closure may be performed. While this surgery is being performed, the nurse should continue with Step 5.

5) Patients should be given Antivenin (*Crotalidae*) Polyvalent Wyeth. If this drug is not available in the hospital pharmacy, it may be obtained by calling the Lincoln Park Zoological Gardens (Area Code 312/549-3000; night emergency, 761-4414). A sensitivity test should be done as directed by the literature accompanying the antivenin serum.

A. If the patient is not allergic to horse serum, the recommended dose of antivenin should be given as follows. One cc. of adrenalin 1:1000 should be drawn into a syringe and kept ready should anaphylaxis occur. The total dose of antivenin to be given depends on the amount of venom injected and can be determined from the literature accompanying the drug.

(1) For bites of the face or neck the entire dose should be given intravenously, following the directions on the antivenin literature.

(2) For bites of the hands or feet, one-half of the dose should be given intravenously, and one-half in a large muscle of the affected extremity.

(3) For bites of the rest of the body, one-third of the total dose should be given intravenously, one-third in the subcutaneous tissue around the bite, and one-third in a large muscle of the affected extremity.

B. If the patient is allergic to horse serum, begin desensitization as directed in the antivenin literature.

6) After antivenin has been given, remove the tourniquet, place a large sterile pressure dressing over the wound, and immobilize the affected part. Ice packs should be placed over the dressed wound.

7) Repeatedly observe and record the respiration rate, pulse rate and blood pressure. If shock ensues, treat with fluids or vasopressors as determined by the central venous pressure and hematocrit.

8) If the patient has been previously immunized against tetanus, he should be given a booster dose of tetanus toxoid. If the patient has never been immunized, he should be given human tetanus immune globulin and tetanus toxoid.

9) Antibiotics consisting of intravenous aqueous penicillin, five million units every six hours and intramuscular streptomycin, 0.5 gm. every 12 hours, should be given daily for three days. If the patient is allergic to penicillin, a broad spectrum antibiotic should be substituted.

10) Insert indwelling urinary catheter and record hourly urinary output. The urine should be analyzed for blood and free hemoglobin.

11) If free hemoglobin is present in the urine, urine output should be maintained above 60 cc/hr. with intravenous fluids and mannitol.

12) Keep the patient warm with blankets.

13) Use aspirin to control pain. If pain is severe and there is no respiratory distress, morphine sulfate may be given.

14) Phenobarbital can be given to allay apprehension if there is not respiratory distress.

15) Transfer the patient to the intensive care unit where vital signs must be recorded every 15 minutes. Serum electrolytes, blood urea nitrogen, and serum calcium measurements should be obtained at six hours and repeated daily. A complete blood count should be obtained every six hours.

16) Patients whose symptoms recur usually require additional antivenin. Symptoms may reoccur as long as three days after injury.

If the offending snake has been positively identified as a rattlesnake and envenomization has

not occurred as evidenced by absence of all symptoms, the following steps should be taken:
1) Begin intravenous fluids and draw blood for complete blood count.
2) Remove the tourniquet.
3) Cleanse wound and apply a sterile dressing and splint.
4) Begin appropriate tetanus prophylaxis.
5) Begin antibiotic therapy as above.
6) Admit the patient for observation.

Summary

Massasauga rattlesnakes inhabit the Chicago area. Although this snake bite is rare, it can be fatal. Physicians must be aware of the symptoms of envenomization and be prepared to institute early treatment.

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Health Rights Act based on Illinois physicians' opinions

Some 10,000 practicing physicians in Illinois were sent questionnaires for advice on national health care reform by U.S. Senator Charles H. Percy on March 5. The 2,500 responses resulted in the introduction of the Health Rights Act, by Senators Scott (Penn.) and Percy on April 21, which the Senators feel reflect the opinions and recommendations specified in the responses.

The Health Rights Act will provide protection for all against the financial calamity of catastrophic illnesses, supplemented by comprehensive outpatient coverage. The major emphasis of this act, however, is on outpatient coverage.

Everyone is eligible for the benefits provided by the plan and pays according to his income. The plan is totally voluntary and protects through Federal financing those unable to financially meet their health care costs.

While the plan provides strong Federal participation, it also draws on private enterprise system. In addition the Act provides incentives for doctors to locate in areas where there is a shortage of medical personnel.

Following is a brief summary of questionnaire responses:

- More than 85% favored federal incentives to encourage doctors to locate in rural and ghetto areas;
- Over 85% favored administering health plans through private insurance companies; two-thirds of the respondents favored a voluntary plan over a compulsory one, but specified that a voluntary plan should be available for those who could afford it, while compulsory plans should be for the poor;
- None of the plans—Administration, Kennedy, AMA, or AHA—were overwhelmingly in favor. Competition was between the Administration and the AMA. The Northern regions favored the Administration, while the Central and Southern regions favored the AMA.

Respondents repeatedly commented on the following issues: Today's health care system; general health insurance coverage; catastrophic coverage; medical personnel shortage; and malpractice suits.

Method of peer review for cancer cure

By tabulating the results of individual hospital cancer registries and submitting the findings to a computer service for statistical analysis.

By Paul Francis Nora, M.D., Ph.D. and Robert Michael Vanecko, M.D. /Chicago

Synopsis-Abstract

A method is described whereby the individual hospital cancer registry can be utilized for peer review in the treatment of the more common cancers in that institution. Essentially, the method consists of tabulating the results of individual hospital cancer registries, and submitting these findings to a larger computer service for statistical analysis.

Specifically, cases of carcinoma of the gallbladder in the State of Illinois were used for this pilot study. The study is in general agreement with other reports of the poor prognosis, short survival time and the ineffectiveness of radical therapy in cases of carcinoma of the gallbladder.

Introduction

Currently, the medical and lay press reflect an intense interest of the public at large and the medical profession in such topics as the information explosion, delivery of health care, and quality control. We are told standardization and continual evaluation of medical therapy will be imposed by outside forces, if not established by the profession itself. One approach which has met with varying enthusiasm is peer review. In an attempt to make this method more objective, and less time consuming for the practicing physician, we considered the following:

A. Computer technology is already in a highly sophisticated state of development; and in use for medically related problems. It is readily available to many medical centers and hospitals on a research or administrative level.

B. Many disease entities have been carefully studied in the past, and reliable statistics are available from large numbers of cases, collected either from the experience of a particular institution, or through a compilation of reports in the medical literature.

C. Specific facts concerning the stage of the malignant neoplastic disease at the time of diagnosis and the results of treatment have been collected in a totally objective fashion, in a great number of hospitals for some time now, in the form of Cancer Registries.

These readily available facts, combined with computer techniques, could be used to determine how the overall results of medical treatment in a locale compare with those reported in the literature, and how the results from the individual institutions within the locale compare with one another.

To test these premises a pilot study was carried out under the auspices of the Hospital Cancer Programs Committee of the American Cancer Society, Illinois Division. The disease chosen for study was carcinoma of the gallbladder. This was done because of the limited number of cases which occur, the certainty of diagnosis, and the consistent, well established statistics in the literature. It also provided an opportunity to evaluate the core data as found in the Cancer Registries.

Methods

Information was requested from the 45 hospitals within the State of Illinois with Tumor Registries in operation since 1958. Hospitals were asked to forward certain information contained in their tumor registries on all cases of carcinoma of the gallbladder which were encountered during a ten year period (1958 to 1968). The following information concerning each case was to be supplied:

1. Age of patient
2. Sex of patient
3. Date of diagnosis
4. Stage of the disease when diagnosed
5. Presence or absence of calculi
6. Histologic type of cancer
7. Treatment
8. Survival time in months

If any one of these particulars was not available in the registry data, it was considered undetermined, and no sources of information other than the cancer registry file were to be consulted.

Twenty-three (51%) of the 45 hospitals returned the requested information. No pressure or inducements were used to obtain this unusually good response. Six other institutions stated that they had no cases of carcinoma of the gall bladder listed in their registry. Two institutions no longer had approved tumor registries. Only nine hospitals failed to respond to the questionaire.

This survey supplied data on 369 cases. Using computer methods, each variable was examined individually, and then each variable was compared with every other variable. The statistical results were reported in terms of percentages, medians, and chi squares. Other statistical techniques were employed, but added little interpretation of the results. It was also possible to compare data from the hospitals with ten or more cases, with the whole series, and against each other.

The same type of information was then obtained from two extensive reviews of the literature. Arminski,[1] in 1949, analysed the findings of over 2,000 cases of carcinoma of the gallbladder that were found in the world literature. In 1960, Strauch[2] presented a cumulative review of over 1,000 cases reported in the medical literature during the preceding ten years. Information was also analyzed from reviews of the experiences encountered in single institutions, namely the Lahey Clinic,[3] Peter Bent Brigham Hospital,[4] and Presbyterian St. Luke's Hospital in Chicago.[5]

Results

The information concerning carcinoma of the gallbladder, as determined by this survey, and compared with other reports is presented in Tables Ia and Ib.

Age—The average age of the patient was 68.4. Less than 1% of the patients were under 41 years of age, but 74.1% were beyond the age of 63. The youngest was 21, the oldest 91. In the largest series reported in the literature,[1] the average age was 62.4, with the youngest patient 22, and the oldest 90. In the experience of a series from a single institution,[3] the average age was 61, with the youngest 35, and the oldest 86.

Sex—In this series, there were 94 males, and 275 females. Thus, 74.5% of the cases occurred in females. This factor is a remarkably consistent statistic in both the large series collected from



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Peer review in cancer

Table Ia

	Age		Sex		Percent with Calculi*
	Range	Median	%Female	%Male	
Arminski (2,000)	22-90	62.4	73.1%	26.9%	73.2%
Strauch (1,000)	29-87	60	75.3%	24.7%	72%
Lahey Clinic (105)	35-86	61	76%	24%	90%
Peter Bent Brigham (78)	27-82	60	82%	18%	90%
Presbyterian St. Luke's (50)	32-83	65	68%	32%	Not Given
Present Series (369)	21-91	68.4	74.5%	25.5%	72%

*These percentages are based only on those cases where a definite statement was made as to the presence or absence of stones. Cases where no statement was made were excluded in arriving at these percentages.

Table Ib

	Pathologic Type		Treatment		Five Year Survival
	%Adeno-carcinoma	% Squamous Cell	Biopsy	Cholecystectomy	
Arminski (2,000)	94.4%	3.8%	50%	37%	Not Given
Strauch (1,000)	85.4%	3.3%			0-3%
Lahey Clinic (105)	63%	2%		40%	5%
Peter Bent Brigham (78)	77%	3%	50%	29%	2.6%
Presbyterian St. Luke's (50)	98%	2%	52%	38%	2%
Present Series (369)	95%	3.7%	55%	37%	0.5%

the literature (73.1%)[1] and in large series from single institutions. For example Lahey Clinic reported 76%.[3]

Stage—The value of staging in determining the efficacy of therapy, and the prognosis is well established. Unfortunately, this factor was not discernible in the majority of large series of cases reported in the literature. In the present series, the following criteria for staging were used (Fig. 1).

Stage I—The disease is limited to the gallbladder wall with no extension beyond the serosa. There is no evidence of metastases. There were 48 cases meeting these criteria.

Stage II—The disease is located primarily in the gallbladder wall, with direct extension to the serosa, and to liver tissue, but no evidence of metastases. There were 66 cases.

Stage III—Disease which is mainly in the gallbladder wall with cystic duct and/or lymph node metastases. There were 56 cases in this category.

State IV—Disease is present in the gallbladder wall with extension to organs other than the liver and/or lymph node metastases. There were 159 cases.

Histologic Type—Ninety-five per cent, or 343 were adenocarcinoma, and five cases (1.3%) were squamous cell carcinoma. In 13 cases (3.7%), the type was undetermined. In the Arminski series,[1] 94.4% were adenocarcinoma, and 3.8% were squamous cell carcinoma. In several series from individual institutions [Lahey Clinic,[3] Presbyterian St. Luke's Hospital,[5] Peter Bent Brigham Hospital[4]] adenocarcinoma made up between 63% and 70% of the cases, squamous cell carcinoma, a rather consistent two per cent. The remainder of the cases in all these series, including ours, was undetermined. Although adenocarcinomas are frequently further divided into serous, papillary, and mucoid in pathology texts, it was not possible to obtain this breakdown from the cancer registries, or from the selected reports in the literature.

Calculi—In this series, the presence or absence of stones could be ascertained from the registry file in only 50% of the cases (182/369). Calculi were present in 131, and a definite statement as to absence was made in 51 cases. In the remaining cases, the situation is not known. In those cases where information is available 72% of the cases have stones. In the Arminski series,[1] 73.2% had stones, and in Strauch's series,[2] 72%. In the series reported from the Lahey Clinic,[3] information was also available in only 50% of the cases. However, in those cases where it was available, calculi were present in 90%. This was also true for the series from the Peter Bent Brigham Hospital.[4]

Treatment—In the selective reports from the literature, uniformly 50% of the cases had laparotomy and biopsy only. Between 30% and 40% had cholecystectomy. The remainder had

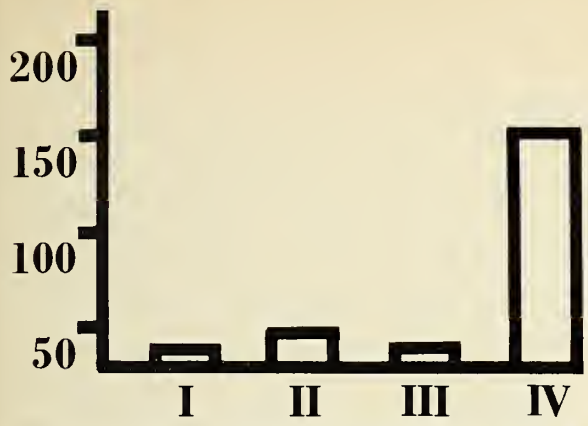


Fig. 1. Schematic diagram showing the stage of the disease of patients with carcinoma of the gallbladder in this area.

a variety of procedures and combinations of procedures. In the present review, 55% had laparotomy and biopsy only, and 37% had cholecystectomy only.

Survival—All reports substantiate the extremely poor prognosis in this disease. Five year survival as reported in the literature, ranges from zero to two per cent, with an occasional series reporting survival of three to five per cent. Usually 95% of the patients are dead within the first year. There were five, five year survivals in this series, or less than 0.5% at the time of the study.

Discussion

The statistics usually readily available and considered pertinent to a disease entity were obtained from a state-wide survey of cancer registries. This data was compared to the reported experience of several large referral centers, and from extensive literature review articles. Data available from these various sources presents a rather uniform picture of carcinoma of the gallbladder, when one considers the age and sex distribution, mode of therapy used and the survival. This would indicate that the data contained in the cancer registries in the State of Illinois contain a representative series for the study of carcinoma of the gallbladder.

Modern computer technology easily enabled further analysis of the present data to determine if meaningful comparisons could be made between individual contributing institutions and the whole series. In actual fact, no attempt was made to focus on any particular institution. The program was set up to compare each of the variables to all others, and to compare these variables as reported by the individual institutions to the whole series. It would be pointless to place all of the statistics before the reader. Some of the hopefully more useful observations will be discussed.

Survival is the main index for evaluating therapy for malignant disease. Since it is hoped that this type of study may help in evaluating and standardizing care, the analysis of survival data are paramount. Table II tabulates the percentage of patients who die within a given time period after the discovery of their disease. This is analysed for the entire series and for those hospitals with ten or more reported cases. It is evident that the findings are remarkably constant.

The reason for comparing death rate in this series rather than survival is two-fold:

1. The number of long term survivals (five years) is minimal, and does not lend itself to meaningful comparisons.
2. Death rates are more satisfactory to compare than short term survivals (six months to three years) because death is a better end point. This is particularly true when a great number of the survivals at the time of the study are short term.

In 14 of the cases, we were unable to ascertain whether they were alive or dead from the material provided by the cancer registries.

Another index that hopefully may be used in determining the quality of care, at least in relation to cancer, is the stage of the disease at the time of the initial diagnosis. Table III illustrates a comparison of the percentage of cases in the various stages of the disease at the time of diagnosis. Here again, one can see that when institutions have ten or more cases, they reflect findings comparable to the series as a whole. We

Table II
Dead Rate

Period in Months	Total Institutions (369) Cases	Per Cent	Institutions with 10 or More Cases (332) Cases	Per Cent
0-6	270	73%	243	73%
6-12	46	12%	41	12%
12-24	16	4%	15	5%
24-36	3	1%	2	1%
36-48	6	2%	6	2%
48-60	0	0%	0	0%
60-120	2	1%	1	1%
	343	93%	308	93%

Table III

Stage of the Disease at Time of Diagnosis

Stage	Total	Institutions with 10 or More Cases
I	48	43
II	66	52
III	56	42
IV	159	148

were unable to do a comparison of our series in terms of staging with other large series, because most authors have not published the stages for their cases.

An analysis of the mortality rate was also undertaken to determine if there were any factors which may affect the incidence of deaths among these patients. The most obvious place to begin was to see if there was some relationship between the stage of the illness and the mortality rate. Here it was found that of those persons still alive, 61.5% were diagnosed during the first stage of the illness, 32.1% during the second stage, and the remaining 15.4% during the third and fourth stages. In terms of the months of survival after initial diagnosis, patients in the first stage of cancer tended to live longer with a median of seven months, while patients in the second, third, and fourth stages had a median survival of only three, two, and one months respectively.

When the effect of treatment on mortality is evaluated, one finds that of the 12 patients alive at the time the study was done, all of them were treated by either biopsy alone, or cholecystectomy, with ten out of these 12 patients (83.3%) being treated by the latter. Seven patients were subjected to more radical therapy, and none lived longer than eight months. This tends to show the ineffectiveness of radical surgical treatment.

Patients treated by cholecystectomy also tended to have longer survival time, with a median of five months survival compared to patients treated by biopsy alone, with a median of only two months survival. This is not a surprising finding because biopsy alone is most likely to be the only treatment in the more severe cases of cancer of the gallbladder.

The data supplied by the hospitals provided an excellent opportunity to test the validity of a commonly held belief that women tend to have a greater incidence of cancer of the gallbladder whether calculi are present or not. There is a definite tendency towards the female sex for carcinoma of the gallbladder ($P<.01$). Examination of Table IV will show that of the women who had cancer, 77.1% had calculi, while calculi were only found in 54.8% of the men. When attention is focused on patients who do not have calculi, there is still a larger percent of females with cancer ($P< .05$). It can be concluded that women will have a higher incidence of cancer of the gallbladder irrespective of whether calculi are present.

If this type of study was employed with more common neoplasms with a better prognosis, then the long term survival comparisons could be done. This would enable the individual institutions to be compared with each other and with those in the area. This could be of value in improving quality control. Specifically, individual hospitals could tabulate their results for carcinoma of the cervix, breast, colon, etc., and then forward the results to a central body, such as a State Computer Center. Then, quite simply, they could compute both core data (survival, staging) and any other possibly related facts, by subjecting them to computer analysis.

Peer review in treatment of carcinoma is considered an essential part of quality control. The methods described here would be easily implemented and could be utilized even in small community hospitals for the more common malignancies. Additional information such as the relationship of carcinoma of the gallbladder to the incidence of calculi in this review, could be an additional reward.

Table IV

Incidence of Calculi in Males and Females And the Sex Distribution of Patients Having Cancer But No Calculi

		Percent
Males (N=42)		
With Calculi	23	54.8%
Without Calculi	19	45.2%
Females (N=140)		
With Calculi	108	77.1%
Without Calculi	32	22.8%
Without Calculi (N=51)		
Males	19	37.2%
Females	32	62.8%

(References on page 168) ◄

Obesity

A much neglected public health problem

By James H. Hutton, M.D./Chicago

For centuries, the problems of obesity have intrigued medical men. Hippocrates, Celsus, and Galen wrote something about it. Shakespeare mentioned it in his play "Julius Caesar." It was regarded as due to some metabolic disorder, and in 1940 Rony[1] said, "those who become obese apparently have an intrinsic tendency toward obesity. . . . It ordinarily develops spontaneously; some intrinsic abnormality seems to induce the body to establish positive caloric balance leading to fat accumulation. Positive caloric balance would be, then, a result rather than a cause of the condition." This attitude continued until—unfortunately for obese persons—some bright young man announced that the human body did not violate the second law of thermodynamics. The obese one took in more calories than he expended and the excess was stored as fat. From this it was argued that obesity was merely a matter of gluttony. All the over-weight individual needed to do was decrease his intake or increase his output, or both, and lose weight. Immediately the treatment of obesity became such a simple matter that most medical men felt it no longer merited their serious attention. The fat one was the villain as well as the victim of the plot.

The *Chicago Tribune* in an October 27, 1970, headline said "Obesity is epidemic in the United States" and quoted Dr. Rimm as saying, "If the money spent for policing marijuana was spent on obesity much more could be accomplished."

Obesity is a threat to health, to social and domestic happiness, and to economic security. It is one of our most important problems. It is one of the nastiest things that can happen to a woman, particularly a young woman. She becomes a social, economic and emotional cripple.

The idea that all the world loves a fat man is completely erroneous. It loves a fat woman even less. An alcoholic is viewed more charitably than a fat woman. Social disapproval is so marked that many fat women develop a self-dislike, often commenting, "I hate myself." This is a most unfortunate attitude and militates against the success of any reducing program. We try to

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Obesity

explain that their obesity is not their fault but their misfortune. We also try to keep them from indulging in self pity.

It is the only malady afflicting the human animal that excites no sympathy for the victim. The idea that fat people are happy is completely erroneous.

In 1967, Dr. Jean Mayer[2] said we had quadrupled our expenditures for health in the previous 20 years but we had experienced no increase in life expectancy. In 1945, this country was fifth in the world in life expectancy for men at age 20. Today we are thirty-seventh. For women we were also about fifth in 1945, but twenty-second today. Dr. Mayer said there was no nation on earth where men exercised so little. He thought we were eating less as a nation but our physical activity was decreasing at a greater speed. He said that efforts to help obese people had been unsuccessful in the middle class society but had been effectual in areas of ignorance and poverty.

Etiology

Why do people get fat? Obviously fat comes only from food and drink, but that explains nothing. The fact that victims of polio while confined to an iron lung can take a great deal more food than their caloric requirement without getting fat has not been explained. All adults have probably noted among their acquaintances people who have maintained the same weight over most of their adult lives. In this connection Rony[1] said that DuBois had calculated that to maintain body weight at a constant level over a period of 20 years one would have to adjust food intake and energy output with an accuracy of 0.05%, an exactness equaled by few mechanical devices and almost no biological processes. Such adjustment would not be possible without a specific mechanism. If we ascribe such a mechanism to our fortunate friends and patients of normal weight, why not extend the same charitable attitude to the victims of obesity and admit that they probably never had such a mechanism or that it became deranged or crippled in some way? As Heald[3] said, "For too long we have considered obesity primarily a gourmet-determined syndrome."

Many causes of obesity begin in childhood from what is known as the "clean plate syndrome." The mother insists that the child eat everything she puts on the plate and the adult continues to do the same thing. Its onset often follows a change of environment. The child moves from one district where he had many friends to one where he has none, or the family may move from one city where they have friends to a strange place. This leads to loneliness which is compensated for by increasing the food intake. The question, of course, is why doesn't everyone subject to these changes become obese?

The onset may follow physical trauma, such as an operative procedure—T & A, appendectomy, removal of a gallbladder, hysterectomy, severe fracture—or an emotional strain—the death of a loved one, a disappointing love affair, financial loss. The interesting thing is that under these pressures some people get fat and those who tend to be underweight tend to become thinner. Joan Beck[4] of the *Chicago Tribune* once questioned, "How much overweight is caused by what an individual eats and how much by what is eating him?"

Gordon[5] has done obese individuals and physicians a kindness by pointing out that there are 27 metabolic differences between the obese and the non-obese patient. He points out that the discoveries of these abnormalities have come from different laboratories and not all of them are present in every obese body. This should help to dispel the myth that obesity is simply due to over-eating.

We do not know what part heredity plays; for example, why sometimes only one member of a family gets fat, and often times it is the daughter.

An increasing number feel that the cause of obesity lies somewhere in the pituitary-hypothalamic area. There are a number of etiological factors which operate through their influence on this center.

Treatment

What can we do for these unfortunate patients? We should remember Plato's remark to the effect that the human animal consists of a body and a soul and when one doesn't function well neither does the other. We can treat them with the same empathy and compassion we extend to other patients. They are ill, or they would not be in our office. A sympathetic listener

*Presented at Illinois Central Hospital.

is a rarity with them. They should not be criticized.

The history should cover the usual points and go into the social, domestic and economic climate in detail. We sometimes ask patients to write their autobiography. Get the chronological story of the obesity and the age of onset. Has any reducing program ever been attempted? If so, what was it and what were the results? If they lost weight, why was the program discontinued? Why does the patient come to you now?

Some people are not suitable candidates for any reducing program. If we could recognize such cases before any program is instituted, we could save the patient money and our time. Unhappily, we usually find this out after treatment is initiated. The patient who says, "I have seen many doctors, have had all kinds of shots and pills and diets," "Food has nothing to do with it," "I do not eat much," "I couldn't live on less," "Dieting does no good," is not likely to do well on any regimen until these misapprehensions are corrected. Unfortunately, however little the patient is presently eating, the intake will have to be reduced or modified. When patients say they don't eat much don't challenge the statement too quickly. Many obese persons are not large eaters. *Every obese person has an appetite too large for him.*

Find out what the patient eats. It is pointless to ask patients to tell you what, when and how much food they eat. Ask them to keep a scratch pad with them at all times, and when they propose to eat or drink anything they should put it on the pad before they put it in their mouths. A food record of a number of days will give a good idea of what one has to contend with in the way of the patient's eating habits. In some cases one can simply re-arrange these, taking away some of the most caloric foods, which may be enough to bring about the desired loss. If a patient claims to have a small appetite, and eat very little, but admits to two bowel movements daily one can question the accuracy of his observation as to food intake. Heald,[3] referring to the work of Mayer's group, says that obese youngsters as a group eat less than do the non-obese youngsters. Asking them to reduce their caloric intake is a severe sentence, and should not be imposed without serious consideration.

Go into the domestic situation fully. Is the husband irritated by the wife's obesity? Does he make nasty remarks about it? Will he help her and cooperate in any reducing regimen? If he will not, the chances for success are considerably diminished. The wife's obesity may threaten the marriage. Maybe she is so ashamed of her figure that she refuses to put on party clothes or a beach costume and expose herself to public gaze. In such instances the husband may have little difficulty in finding a slimmer substitute. Another and practically unsolvable problem is the family which has a handsome athletic son they praise and a fat slovenly daughter they constantly criticize. The daughter is condemned to a life of fatness and misery unless she gets away from her family. If the patient is a child, what about the parents? Will they leave the child alone? Will they nag the child on dieting? Will they constantly supervise the program? If so, the chances of success are not great. Many times the problem is as much with the parent as it is with the child. I do not hesitate to say to the parents —sometimes in the presence of the child—"Leave the kid alone. If the youngster wants to diet, he will; if he doesn't, he won't. Nagging will do no good."

The first interview may have much to do with the success of whatever program is selected.

Did the weight remain at about the same level for a year or so before taking off for higher figures? If so, when this weight is reached on the way down some time will be required to break through this plateau to lower levels.

Obese patients are so anxious to lose weight that any program that promises to help them to take it off easily can be sold to them. This matter is so serious that Congress once debated enacting a law to protect the obese against racketeers in this field.

After the history, a complete physical examination is done. The history and physical examination may indicate the laboratory work needed; it should include at least a complete blood count, urinalysis, serum cholesterol, uric acid, blood urea nitrogen, postprandial blood sugar and tests of thyroid function. We have been surprised at the number of obese patients who show a diabetic type of sugar curve—a 3-hour glucose tolerance test is done if indicated—and high uric acid. The sugar curve tends to return to normal during treatment and the uric acid often gets higher. Simeons[6] warned that during treatment by his method an acute attack of gout might occur. This has never happened to us but we watch the uric acid and use uricosuric agents as needed.

It would be well if the physical examination and laboratory work were done by some physician other than the one who will treat the obesity. Dr. Jake Flaks[7] of Johannesburg, South

Obesity

Africa, sends his patients to some other internist for this purpose. Siegel's[8] work, is now so well known that doctors refer patients to him solely for the treatment of their obesity. Someone said there is nothing wrong with a fat person that losing weight will not help. This may very well be true, but one must assure himself of the patient's general condition. No one would wish to treat obesity and overlook some other condition of equal or even greater importance.

After the examination and laboratory work are completed, we have another conference with the patient and, when feasible, some member of his—or more often her—family. The laboratory results are explained and again one attempts to convince the patient that losing weight is a three-cornered affair—the patient, the doctor, and the patient's environment. However much we sympathize, the problem is still the patient's and the success of any reducing program depends on the patient. If we could, at this time, convince the patient that the fight against obesity is a life-long affair and that he can never expect to eat as his thin friends do, we would have gone far toward making life more tolerable.

Our armamentarium consists of:

- Diet (including fasting)
- Psychotherapy
- Drugs
 - Multivitamins
 - Diuretics
 - Thyroid—Synthroid—Cytomel
 - Sedatives
 - Appetite depressants
 - The light that failed
 - Digitalis (mentioned only to be condemned)
 - D.B.I.
 - HCG—human chorionic gonadotropin

Diet

Bray[9] discusses the myth of diet in the management of obesity. While gluttony accounts for a small percentage of obese patients, all reducing programs are based on dietary changes. Diets in general may be divided into two classes: those which simply reduce the caloric intake below the level of energy output; and those that change the composition of the diet, usually greatly reducing or leaving out either fat or carbohydrate, allowing the patient to eat more or less freely of the foods allowed.

The earliest of these was the high fat diet used by Harvey, in London, about 1863. It came to be known as the Banting diet—named after the patient who used it. It was more widely publicized in this country by a book "Calories Don't Count" by Dr. Herman Taller.[10] On this diet patients may eat all they want of the foods allowed, and need never be hungry. However, it is a very unappetizing diet.

The high protein diet suggested by Stillman[11] is more appetizing and many patients lose weight on it. Women often fail to lose because they cannot bring themselves to drink the required amount of water.

The Weight Watchers program is now the most popular procedure. Undoubtedly thousands have lost satisfactorily on it. Group psychotherapy plays a prominent role in its success.

Humplik[12] suggests that "it should be possible to feed the overweight patient in such a way that the energy required to assimilate the food exceeds the energy supplied by the food itself, resulting in a depletion of fat stores."

Until recently it was thought that a calorie was a calorie regardless of its source. It is now realized that calories from carbohydrates lead to greater weight gain than those derived from protein or fat, probably because they lead to greater retention of fluid. Sweets are almost as bad for the obese as for the diabetic.

Fasting is used by some men. Gordon[5] used a 48-hour fast followed by a high fat low carbohydrate diet. Duncan[13] has used fasts of varying duration. Hunger is not usually a problem after the first day. For the first time, most patients should be hospitalized if the fast is to last longer than two days. In this hospital we have fasted patients up to 23 days. All of them did well and did not seem to experience any of the ill effects that are said to occur in some cases with this procedure.

Many women can fast easily for one to three days at home. For them fasts are an important part of the reducing program. They should be allowed coffee, tea and water sufficient to quench their thirst and multivitamins. Sometimes a mild sedative and occasionally an antacid may be needed. Fasting should not be urged on women who find it too difficult.

We must not only teach patients what to eat or what not to eat but we must also teach them how to eat—slowly—the slower the better.

Psychotherapy

Most obese patients have some emotional problem. The more vigorously they deny it, the more

serious it is likely to be. Every obese patient should see a psychologist or psychiatrist at least once, but usually the clinician has to do the psychotherapy. Group therapy is very valuable. TOPS is an important organization for obese persons with its results largely dependent on group therapy. Psychotherapy contributes largely to the success of any program.

Drugs

Multivitamins should be used in every reducing program. Diuretics are given as needed; some men take one every seven to ten days, and some women just prior to the menstrual period. Some women with idiopathic edema may need them more frequently. Not all obese patients react the same way to a diuretic and some seem to acquire a tolerance for one and must shift to another. Obese persons get a better reaction if the diuretic is taken at bed time. If diuretics are used regularly the sodium and potassium should be watched.

Thyroid is a much maligned drug. Probably more people need it than get it. Hypothyroidism rarely if ever leads to obesity but obese patients seem to do better if given thyroid to tolerance. Frequent checks of thyroid function are rarely necessary.

Recently Cytomel has come to play a more prominent role in this field. Some claim that it favorably affects the patient when desiccated thyroid is ineffective.

D.B.I. is a newcomer in this field. It is said to increase the oxidation of glucose by muscle and to abolish the increased insulin response. The raised fasting free fatty acid level is decreased by D.B.I.

DiCalcium phosphate with Vitamin D is given to patients on the Simeons program.

Sedatives are occasionally helpful, particularly on fasting days and in the premenstrual week.

Digitalis should not be part of any reducing program except as needed for cardiac conditions.

HCG—marked as Antuitrin-S, A.P.L., and Follutein. Its use was proposed by the late Dr. A. T. W. Simeons more than 20 years ago. In general, the program consists of injections of 125 to 250 units daily or three times weekly depending on circumstances. Simeons gave 125 units daily six times weekly until 40 injections had been given. He then stopped the injections for six weeks, during which time the patient was not expected to lose any more weight. If more weight needed to be lost a second series was begun at that time. He permitted no more than a 35 pound loss in six weeks. If weight was lost during the interval the patient was asked to regain it before the second series of injections was started. When the first series of injections was started the patient was expected to eat very freely while the first three injections were being given. He called these the ineffective injections. Because of transportation and other difficulties we give only three injections of 250 units per week, but we continue the injections several months if necessary. The uric acid, blood sugar, sodium, potassium and blood count are checked as needed.

The diet consists of 100 grams of specified kinds of meat, fish and fowl twice daily with enough low calorie vegetables and fruit to make up to 500 calories per day. Salt is not to be used on the table. Some form of calcium should be used to prevent gingivitis.

HCG seems to do a number of things:

(1) It enables patients to live on this diet with little hunger.
(2) It assists the body to lose weight where the patient wishes it to come off.
(3) It gives women of middle age and beyond a more youthful appearance.
(4) Patients experience a sense of euphoria. Nearly all say they have not felt so well in years.
(5) The many aches and pains which the obese suffer are relieved. Arthritic pains are decreased.
(6) Many women—not all—with brittle finger nails develop new ones of better quality.

It is probable that our results are not as good as when the injections are given daily, but they are better by this method than by any other we have ever used.

Contraindications

Contraindications include serious infections, small gall stones, unless the patient is willing to risk an attack of gall stone colic, and after a coronary attack, the electrocardiogram should have remained stationary for at least nine months.

The presence of cancer is debated. Leading endocrinologists questioned were of the opinion that the only contraindication would be a hormone dependent one as of the breast, uterus, etc. Siegel,[8] who has treated several thousand, says cancer has been less frequent among these patients than among the population at large.

For those patients who can fit this program into their schedule it is one of the nicest things ever done for obese individuals. Unfortunately, it is not widely used. It should be available in

every neighborhood. Its use is condemned by many who know nothing about it. No one who has ever given it a fair trial has anything but praise for it.

Most of our obese patients are women. It has been said that inside every fat woman is an unhappy thin woman. It is our duty to try to liberate this thin woman with a minimum of inconvenience and expense.

No two of us are alike in our finger prints. Obesity is more complicated than finger prints; consequently no one method of treating obesity is likely to be suitable for every fat person. We try to help the patient select a program he seems most likely to follow. We have to consider geography and economics as well as other facets of the problem. A woman living 50 miles from the office and having children can hardly be expected to come to the office three times weekly. She is obviously not a candidate for the Simeons program. Others have to lose weight at a minimum cost, so some plan must be developed that will not require frequent office calls.

Finally, the patient may choose from a number of programs.

She can eat, drink and be merry. Many would save themselves time, trouble and expense by doing just that.

She can elect any one of a number of diets, but she should stick to whichever one she selects. Many failures are due to the fact that patients deviate from the diet, changing a prescribed food for one they consider of equal value.

Prognosis

The long range outlook is poor. Few maintain their weight at the level reached during the reduction program. The reason is that obese patients cannot accept the fact that obesity is like diabetes and is not cured.

Obese persons have more and larger fat cells than persons of normal weight. When weight is lost these cells are partially emptied of their contents, but few are destroyed. They are merely waiting to be refilled. What is needed to protect these unfortunates is an educational program. Williams[14] suggests a widespread campaign of public education.

Arthur J. Snider of the *Chicago Daily News* once suggested a "Be kind to fat folks week." We also need a national organization similar to the American Diabetes Association.

The obese are so desperate in their desire to lose weight that they are easy victims of various rackets alleged to take off weight easily. This brings all of us interested in this field into a delicate situation. Probably most medical men view the treatment of obesity as something beneath their serious attention. Those of us who are seriously interested need to watch our step lest we incur the suspicion of our colleagues. The obese are our most unhappy and neglected patients. They are entitled to the best care any one can extend to them. ◄

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Disposable vs. cloth surgical drapes

By Hugh A. Johnson, M.D./Rockford

Disposable drapes* are of guaranteed sterility. They are moisture resistent. Cloth drapes, on the other hand, when moistened have their sterility compromised. Reason tells one the disposable drapes should be better, but it takes considerable adjustment before acceptance in routine use. Perhaps each type has its place; where asepsis is of utmost importance, disposable drapes should be used; for a well-fitting drape in facial work, cloth head towels and a split sheet are satisfactory. Expense should not enter into this discussion, but if the disposable drapes are more expensive, a wound infection and its extra hospital days and antibiotics can be very expensive as well. More time and care are required when paper is used and "Time is money," (Benjamin Franklin in "Advice to a Young Tradesman") but anesthesia time saved by quick, neat and adequate draping is more than money—it's decreased morbidity for the patient. However, with practice, draping with disposable drapes can be done neatly, artfully, and with dispatch.

Application of head towels is an art. The trick is to get a firm grip on the occiput. This is easy enough with cloth head towels (Figs. 1 & 2) but considerable care is required to get the paper towels to conform (Fig. 3). When an ear must be exposed, the simple expedient of clipping a towel to tape on the forehead (Figs. 4 & 5) is effective. The split sheet gives very adequate coverage of the entire table (Fig. 6).

In hand surgery it is important to have no constriction about the limb and a towel applied as shown in Figure 7 does the job. Here impervious disposable drapes are ideal; almost essential (Figs. 8 & 9).

For hypospadias surgery I've found it useful to clip the towels to the sheet beneath the patient in order to have good exposure of the perineal area (Fig. 10). An added advantage of the disposable drape is easy exposure of a donor site by simply cutting a window wherever desired, (Fig. 11) an advantage in all other cases requiring grafts, especially for hand cases or cross-leg flaps.

I've solved the cross-leg problem with a routine combination of cloth and disposable drapes (Figs. 12, 13 & 14). It is effective even when casts

Barrier (trade mark of Johnson & Johnson) drape provided by product directors R. C. Dawson Jr. & W. H. Summer, Johnson & Johnson, Inc.



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Fig. 1. Careful placement of the head towel under the protruding occiput.



Fig. 2. Cloth towels conform readily.



Fig. 3. Considerable care is required to get the disposable head towels to conform.



Fig. 4. Tape applied to the forehead helps give fixation of head towels when ears must be exposed.



Fig. 5. Exposure of the ear. (Hair is more readily rendered aseptic then skin.)

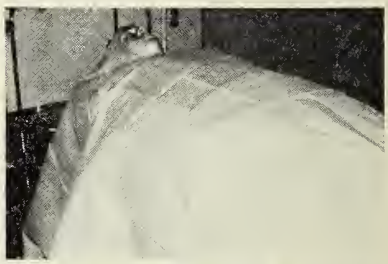


Fig. 6. The split sheet very adequately covers the patient and table.



Fig. 7. Disposable, moisture resistent drapes are almost a must to secure aseptic field in hand surgery. The towel is applied carefully to prevent constriction.



Fig. 8. The split sheet is used for a hand case to be done under regional anesthesia.

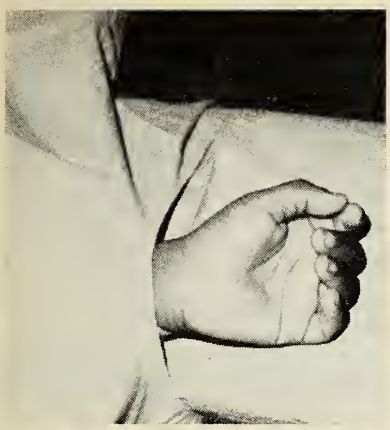


Fig. 9. If larger hand tables are used, the small disposable sheets are useful for impervious cover.



Fig. 10. Disposable towels are clipped to the table cover in order to give good perineal exposure.

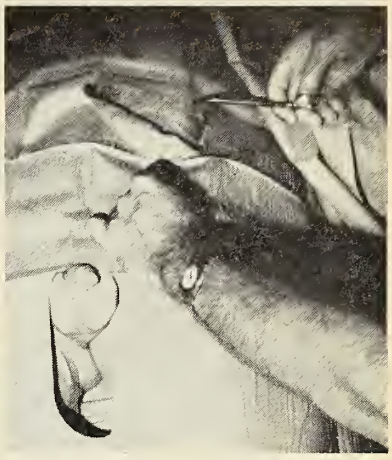


Fig. 11. Completion of the hypospadias drape. Skin graft donor sites are easily exposed by simply cutting a hole.



Fig. 12. Legs prepared en toto then draped separately for a cross leg flap. If casted before surgery, the draping can be done in the same manner.



Fig. 13. Both legs draped with stockinette for a cross leg flap.



Fig. 14. Two disposable split sheets used to complete the draping for a cross leg flap.

are applied prior to surgery. Of course preliminary skin preparation of both legs in their entirety is done in case exposure beyond the planned surgical site is necessary. Two split sheets are used. Again donor site can be exposed by cutting a hole.

At the close of a busy surgical day, the heap of soiled drapes, both cloth and paper is distressing—cloth because one is put in mind of the high cost of labor and the chance that negligence and outdating may introduce contamination; and paper because of the greater contamination of our atmosphere by burning and the destruction of trees to produce the paper. At the Sumner Koch Burn Center where we used only paper for a time, the heap at the end of the day turned me back to cloth-emotion, I know, for waste is of course purely relative when human resourses are concerned.

Disposable vs. cloth drapes

Conclusion

Impervious, disposable drapes, though effective, are difficult to handle. Cloth drapes are still useful in surgery about the face where asepsis is not compelling. A combination of the disposable and cloth drapes is often an advantage.

Impervious, disposable draping is best, but acquisition of skill in its application is necessary. Cloth drapes are perhaps more neat, but once moist they allow sterility to be compromised. A combination of the two materials is often useful. ◄

A questionnaire

On continuing medical education

1. Which of the following do you utilize in your continuing medical education? (Circle all that apply.)
 a. Educational radio-television — Yes No
 b. Audio tapes — Yes No
 c. Formal courses and lectures — Yes No
 d. County, state and American Medical Assoc. meetings — Yes No
 e. Specialty Society and AAGP meetings — Yes No
 f. Hospital staff meetings — Yes No
 g. Medical literature — Yes No
 h. Contacts with professional colleagues — Yes No
 i. Other — Yes No

2. Do you feel ISMS activities in continuing medical education should: (Circle only one.)
 a. Be increased — A
 b. Be decreased — B
 c. Remain the same — C

3. Does the scientific portion of the CMS-ISMS Clinical Conference Annual Meeting provide an important means of your continuing medical education? — Yes No

4. In the past three years have you attended any of the following types of medical meetings?
 a. Illinois State Medical Society Annual — Yes No
 b. American Medical Association — Yes No
 c. Specialty Society or AAGP — Yes No
 d. Voluntary Health Agency — Yes No
 e. Government sponsored — Yes No

RETURN TO:

Committee on Continuing Medical Education
ISMS
360 N. Michigan Avenue
Chicago, Illinois 60601



socio-economic news

a service of the division of health care delivery

By Joseph J. Lotharius

Lawmaker charges delays In Medicare payments

The Bureau of Health Insurance has been asked by Rep. John B. Anderson of Rockford to investigate Medicare claims processing delays by the Continental Casualty Co. (Part B Medicare carrier for most of Illinois). Anderson said he took the action because of numerous complaints from Medicare patients and physicians about the Company's slow payment of claims.

"I hope to get them to make some internal management decisions to make it possible to process claims more quickly," Anderson said. He added that he has not ruled out the possibility of legislation to improve payment services if his efforts fail.

Continental's Medicare spokesmen told ISMS that new processing techniques make it possible for *routine* Medicare claims to be processed and paid within three weeks from the date the claim is received.

Medicaid regulation set By Feds to stop fraud

A heretofore interim policy to help detect fraud in the Medicaid program has now been adopted into federal regulations. The new regulation (which became effective July 26) requires state Medicaid plans to provide criteria for identifying fraudulent situations. It also requires the state plans to establish some method of verifying whether the services billed have actually been provided. This can be accomplished by a random sampling of Medicaid patients. The new regulation requires that all checks to providers contain a statement above the endorsement area which, when signed, makes the payee liable for any false claims or fraudulent action.

The Illinois Department of Public Aid, administrator of the Illinois Medicaid program, said a statement such as this already appears on all payment vouchers which complies with the federal regulation. IDPA does not anticipate the need for any further action at this time.

AMA fails To endorse HMOs

AMA Delegates did not endorse health maintenance organizations during the 1971 Convention because HMOs are still experimental and unproven as a nationally applicable solution to problems of health care delivery. Delegates also voiced regret at the wide government support given HMOs prior to obtaining valid proof of their effectiveness.

AMA endorses outpatient Surgery as good medical Practice

An ISMS sponsored resolution asking that outpatient surgery under selected conditions be made a part of good medical practice was endorsed by AMA Delegates during their recent convention. It was stressed, however, that access to adequate back-up facilities for hospitalization should be present, if needed, when such surgery is performed.

Not all MDs favor Foundations

Not all DuPage County physicians favor the establishment of a foundation for medical care in their area, according to a letter circulated to county society members. The letter, which contains the signatures of 48 MDs, states "that great pressures have been brought to bear in order to establish foundations and that our membership has not been given either a clear survey of these systems (FMCs) or adequate time to consider the arguments against the foundations." The letter says the establishment of an FMC means the complete administrative mechanism will have been set up ready for "politicians to take over." Sponsors of the letter urge their colleagues to oppose establishment of a DuPage County FMC.

Business problem solutions offered In brochure by consultants

Need advice from someone with no axe to grind? That's the question asked by a new 8-page brochure offered to doctors by the Society of Professional Business Consultants. This handy booklet tells doctors how and where to get help in solving their business dilemmas.

The Society is a national association of 31 member firms who specialize in counselling physicians and dentists. They stake their existence on the quality of the services they render, because, they say: "No one else pays us. We take no fees or commissions from anyone whose goods, systems or services we recommend. This gives us the objectivity that is vital to anyone who seeks to counsel doctors on management problems."

The brochure explains that while the Society's member firms differ widely in the services they offer, they are active in practice management . . . financial management . . . tax management . . . facilities management . . . and partnership and group management.

The brochure describes Society members as specialists in the economics of medical and dental practice. It says they offer the guidance of a full-time business manager at a part-time cost. "The individual consultant," it explains, "may offer a one-time survey or a continuing supervision service, or both. His charges are governed strictly by the time and expense involved in providing what the client requires."

SPBC members employ more than 225 consultants, serving doctors in all 50 states and some areas of Canada.

For a copy of the "Need Advice?" brochure write: SPBC, 221 N. LaSalle, Chicago, 60601 or call (312) 346-1862.



practice management

File it and find it!

By Robert P. Revenaugh/Professional Business Management, Inc.

Dr. New recently started in private practice. Wishing to set his own mind at ease regarding the business side of his practice, he requested our services in, among other things, setting up a workable and efficient office procedure.

One area of concern was that of the filing of medical and other records and documents. We discussed the various alternatives of filing methods, the several types of files and containers, and the physical location of the files. After considering various combinations, we suggested the following as the best for Dr. New's individual circumstances.

A. Classification

We recommended that there be four basic classifications: 1. Patient Medical Histories. 2. Patient Financial Records. 3. X-Rays and 4. Miscellaneous. The Miscellaneous class is further subdivided into: a. Letters from Patients. b. Income Tax Returns and Correspondence. c. Social Security and Withholding Returns and Correspondence. d. Furniture, Fixtures and Equipment Invoices. e. Office Insurance. f. Personal Insurance. g. Unpaid Bills. h. Paid Bills. i. Laboratory Bills. j. Personal Correspondence and k. Correspondence-Collection Accounts.

B. Housing and Location of Records

1. *Patient Medical Histories.* We recommended that these items be filed in letter-sized manila folders and be placed in a bookcase-type file. We suggested closeable bookcase files because they took a minimum of space, gave a neater appearance to his office and yet could be closed and locked at night. As most of these records will be pulled first thing in the morning and put in order of the day's appointments, there was no absolute need for this file to be located at the reception desk. Rather, we recommended to Dr. New that he place the files so that they would be readily accessible to both his receptionist and his nurse.

2. *Patient Financial Records.* As Dr. New's receptionist also takes care of the posting and billing, it was necessary that these records be handy to her. In this case we suggested tray-type files that could be placed on her desk during the day and could be stored in a file cabinet at night. In this way she would be able to handle both her receptionist and bookkeeping duties while remaining seated at her desk. Paid and unpaid accounts are to be filed separately.

3. *X-rays.* Since these items are oversized and referred to infrequently, we advised the doctor that they be filed in a drawer-type cabinet located in a remote room.

4. *Miscellaneous.* We recommended that because these documents are of a more personal nature to the doctor they be kept in a locked drawer cabinet near the reception desk. Letter-sized file folders were made up for each subdivision.

C. Other Recommendations

To make all records as easily accessible as possible, we recommended that they all be filed in alphabetical rather than numeric sequence. This eliminated the need for cross-indexing, thus lessening work and confusion. A color coding system (orange for A-D, yellow for E-H, green for

(Continued on next page)

File it and find it

I-N, blue for O-Q and purple for R-Z) was discussed and implemented as a guard against misfiling of medical records.

So many doctors' filing systems are in his Girl Friday's head that when she departs, the office filing system leaves with her. A good system has a written index and description of its operation, is known to, and is followed by the entire staff, and easily taught to a successor.

The end product of any filing system is the ease of information retrieval. In working with doctors for many years on the business side of practice I have learned that when the office staff cannot quickly present their doctor with the document he wishes, it is a certain tip-off to an ineffective filing system. Order, through proper filing, is one of the fundamentals of an efficient office.

Clinics for crippled children

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Division will hold 22 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be six special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

Sept. 1—Carmi Township Hospital
Sept. 1—Hinsdale—Hinsdale Sanitarium
Sept. 2—Sterling—Community General Hospital
Sept. 2—Effingham—St. Anthony Memorial Hospital
Sept. 2—Lake County Cardiac—Victory Memorial Hospital
Sept. 7—Alton—Alton Memorial Hospital
Sept. 8—Champaign-Urbana—McKinley Hospital
Sept. 8—Joliet—St. Joseph's Hospital
Sept. 9—Springfield—St. John's Hospital
Sept. 9—Macomb—McDonough District Hospital
Sept. 9—Anna—Union County Hospital
Sept. 10—Chicago Heights Cardiac—St. James Hospital
Sept. 14—East St. Louis—Christian Welfare Hospital
Sept. 14—Peoria—St. Francis Children's Hospital
Sept. 15—Jacksonville—Norris Hospital
Sept. 15—Evergreen Park—Little Company of Mary Hospital
Sept. 16—Decatur—Decatur Memorial Hospital
Sept. 16—Rockford—Rockford Memorial Hospital
Sept. 16—Elmhurst Cardiac—Memorial Hospital of DuPage County
Sept. 17—Chicago Heights Cardiac—St. James Hospital
Sept. 21—Belleville—St. Elizabeth's Hospital
Sept. 21—Rock Island Area General—Moline Public Hospital
Sept. 22—Springfield Pediatric Neurological—Diocesan Center
Sept. 22—Centralia—St. Mary's Hospital
Sept. 22—Elgin—Sherman Hospital
Sept. 23—DuQuoin—Marshall-Browning Hospital
Sept. 24—Chicago Heights Cardiac—St. James Hospital
Sept. 27—Peoria Cardiac—St. Francis Children's Hospital
Sept. 28—Peoria—St. Francis Children's Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

the peer reviewer

Council on Economics and Peer Review

division of health care delivery

JULY, 1971 Vol. 1 No. 2

GOVERNOR OGILVIE GAVE LEGAL IMMUNITY TO PHYSICIANS SERVING ON PEER REVIEW COMMITTEES when he signed HB-1881 into law. This legislation was initiated by Illinois State Medical Society and gives legal protection to physicians serving on all peer review and medical review committees.

AN EXPRESSION OF MEDICINE'S DEEP COMMITMENT TO THE PRINCIPLE OF PEER REVIEW was reflected in a position statement adopted at the AMA convention by the House of Delegates. The resolution adopted calls for AMA and its component state associations to "reaffirm their support of voluntary mechanisms of review and education by physicians such as grievance committees, insurance review committees, and hospital review mechanisms." AMA Delegates also asked that every component association oppose any peer review proposal which would not allow this professional function to be carried out by county and state medical societies.

DEFINITIONS FOR PEER REVIEW, MEDICAL PRACTICE ANALYSIS AND CLAIMS REVIEW were adopted by the AMA's House of Delegates in June. Their action was taken to clarify these terms which have been frequently used inappropriately. The accepted definitions of these terms are:

PEER REVIEW -- Evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians. Peer review is the all-inclusive term for medical review efforts. Medical practice analysis, inpatient hospital and extended care facility utilization review; medical audit; ambulatory care review; and claims review are all aspects of peer review.

MEDICAL PRACTICE ANALYSIS -- A function of the medical society, or other organization authorized by the medical society, designed to coordinate all peer review efforts of a community. Medical practice analysis focuses on the development and application of criteria for optimal medical care, and evaluates the individual and collective quality, volume, and cost of medical care, wherever provided.

CLAIMS REVIEW -- Peer evaluation and adjudication of claims questions referred for peer review by any party with a valid interest in the case.

A NEW COMPREHENSIVE PEER REVIEW MANUAL TELLING HOW TO DO PEER REVIEW IS NOW AVAILABLE from the American Medical Association. The two volume manual, selling for $4.00, is a highly informative compilation of the development and operation of a peer review program.

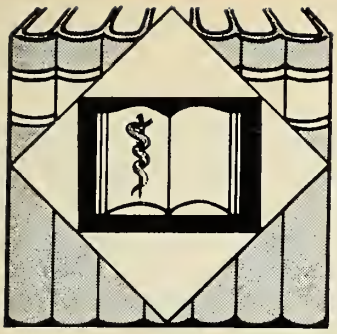
The Peer Review Manual, in a loose-leaf format, tells how to:

* determine the composition of a peer review committee
* formulate methods to activate peer review
* delineate areas of review effort
* publicize peer review activities
* establish the line of appeal

The Manual also includes information on:

* guidelines for evaluation and quality
* hospital utilization review
* staffing and sources of funding
* data collection and analysis
* pertinent legal considerations
* examples of local peer review programs
* data sources and forms

Copies of the Peer Review Manual (OP-360) can be ordered from the American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.



the doctors library

Becker-Shaffer's Diagnosis and Therapy of the Glaucomas. By Allan B. Kolker, M.D. and John Hetherington, M.D. C. V. Mosby Company, St. Louis, 1970, 495 pages, 383 illustrations, six color plates.

The major difference between this edition and the previous ones is apparent from a glance at the cover. An apostrophe "s" has been added after Shaffer indicating that the original authors have now become senior statesmen and have turned over the task of editing their third edition to their younger associates. They have chosen well.

The first edition appeared in 1961 and was warmly received by the ophthalmologic world because it represented a summation of the American or mechanical concept of glaucoma by the two men who were most responsible for promulgating and developing that concept. Within four years a second edition was necessary. This contained many new developments such as the genetics of glaucoma, electron microscopy of glaucomatous eyes and excellent photographs of angles.

This new third edition by Kolker and Hetherington continues the general format and chapter headings of previous editions. However, there has been a marked expansion of some of the chapters. For example, the chapter on optic discs has doubled from eight pages to 15. There is a much more extensive discussion of the blood supply of the optic nerve head and a review of fluoro-angiography of the disc, a subject not discussed five years ago and thus absent in the previous edition. Similar comments apply to the sections on static perimetry and internal filtering operations.

In summary, this continues to be the standard text on glaucoma and this new third edition brings up to date a most valuable book. No ophthalmologist can afford to be without it.

David Shoch, M.D.

An Introduction to Neurosurgery. By W. Bryan Jennett.

This very concise and easy to read book adheres faithfully to its title. It is classical in its organization, beginning with a comprehensive discussion of intracranial pressure, and then passing smoothly into a declension of all those neurosurgical lesions which cause intracranial hypertension. Each symptom and sign is discussed thoroughly with an economy of words, and a clarity of concept. The reader is foremost in the mind of Mr. Jennett as he addresses himself to the physician not engaged on a day-to-day basis with neurosurgical problems.

The sections on pre- and post-operative care are most helpful to the referring physician who desires concise knowledge concerning all phases of the management of the patient he has referred to the neurosurgeon. Pertinent information concerning the nature, incidence, biology and treatment of brain tumors is interwoven deftly with the diagnostic studies and surgical results. Some sections, however, such as head injuries betray the authors extensive experience, in that generalities sneak into the text, and assumptions are wanting in documentation: i.e. the sections in primary and secondary lesions in the pathology of head injuries. These negligible defects are more than compensated for as one passes on to read with delight the clarity of concept expressed in the sections on care in hospital, and effects of airway obstruction.

Spinal lesions are particularly well handled and clearly illustrated. Diagrams advantageously accompany roentgenograms. In this day of ever expanding interest in pediatric neurosurgery, one wishes that the sections on hydrocephalus and congenital spinal abnormalities either were more extensive or omitted.

The author has satisfied the goal he defined

(Continued on next page)

(Continued from page 153)

for himself in providing "a framework within which more detailed and up to date information can be accommodated."

Anthony J. Raimondi, M.D.

Essentials of Clinical Endocrinology. By Norman G. Schneeberg, M.D. C. V. Mosby Company. St. Louis, 449 pages, 210 illustrations with two color plates, 1970. $22.50.

Few medical specialties are in the continued state of flux which characterizes endocrinology. New advancements and developments are reflected by more or less complete reassessment of previous understandings, frequently requiring complete rewriting of established teachings. For example, consider the impact of cytogenetics or the newly appreciated role of the hypothalamus on gynecologic endocrinology.

The author and his contributors do well in placing recent developments in proper perspective. Schneeberg states in his preface that this book is designed for students, residents and practicing physicians who are untutored in endocrine matters and who seek a didactic introduction or brief review of the subject. Although we are not all endocrinologists, we practice clinical endocrinology all the time. Is there any phase of medicine without its endocrinologic aspect?

The book is divided into 25 chapters from "general principles" through "cytogenetics." It is well printed on heavy glossy stock, and the tables and figures are excellent. The color reproduction in the two color plates is only of fair quality. The short biographical references at the end of most chapters will lead the reader to further study if he so desires.

This is a very fine and valuable book in a rapidly changing field, and the price, is not out of line. I highly recommend it for all practicing physicians, residents, interns and students.

Edwin J. DeCosta, M.D.

Contributions to Clinical Neuropsychology. Edited by Arthur L. Benton, Aldine Publishing Company, Chicago, 1969. 243 pages, several tables.

This small volume provides a concise, definitive, up-to-date compendium of present information on clinical neuropsychology, which is relatively a new science, not more than 20 years old. This discipline utilizes clinical research studies and animal experimentation together with developmental observations to fulfill its purpose of defining the relationship between brain function and human behavior. Obviously, quite a number, as well as a variation of scientific areas, must be present within this aegis.

Eight authorities, each versed in his special area of neuropsychology discusses his specific contributions to this little volume. The chapters are entitled: 1. Modern Trends in Neuropsychology; 2. The Behavioral Effects of Commissural Section; 3. Neuropsychological Studies of the Phantom; 4. Problems in the Anatomical Understanding of the Aphasias; 5. Constructional Apraxia: Some Unanswered Questions; 6. Protopathic and Epicritic Sensation: A Reappraisal; and 7. Auditory Agnesia: A Review and Report of Recent Evidence. Each of these subject titles is geared to its relationship to behavioral syndromes, which are the end products, clinically.

This book holds great value for, and is indeed a useful tool to, the clinical neurologist in the adult or childhood field, for the psychiatrist to adults or to children, to the speech therapist, and to the physical, occupational, and play therapist. The material is well structured and constructed, and easy to read and comprehend in the areas of aphasia, apraxia, agnosia, dyslexia, language retardation, so that it can be easily utilized by these disciplines. Finally, an excellent set of tables in each chapter, with a more than adequate Reference List, at the end of the book, more than enhances its usable values.

Louis D. Boshes, M.D.

A new choice for Americans

"When we ask—what shall be the national priorities and how shall we allocate the national resources—we are asking a question we have never in our history had to ask, a question we never thought that we would have to ask. For the first time we are beginning to realize we can't have everything. If we are to choose some things, we shall have to choose not to have other things." —J. Irwin Miller, chairman, Cummins Engine Co.

what goes on

a guide to continuing education

August 25-28—American Academy of Orthopaedic Surgeons

Emergency Care and Transportation of the Sick and Injured

Fee is $50. For further information write: Emergency Care Conference, The Wisconsin Center, 702 Langdon Street, Madison, Wisconsin 53706

University of Wisconsin Medical Center

August 29-30—American Medical Association

31st Annual AMA Congress on Occupational Health

Jackson Lake Lodge, Grand Teton National Park, Wyoming

September 17-18—University of Texas Graduate School of Biomedical Sciences at Houston Division of Continuing Education

Mike Hogg Intensive Review in Obstetrics and Gynecology

The course will cover recent developments in obstetrics and gynecology. An in-depth review of various topics intended for the practicing physician and candidates for the American Board Examinations will be presented.

For further information write: Office of the Dean, University of Texas Graduate School of Biomedical Sciences at Houston, Div. of Continuing Education, P.O. Box 20367, Houston, Texas 77025.

St. Joseph's Hospital, Houston, Texas

September 12-13—American Academy of Orthopaedic Surgeons

Emergency Service Policy Trends

The meeting is designed for hospital administrators, medical directors and nursing supervisors of emergency departments. For information contact: George T. Anast, M.D., 55 E. Washington Street, Chicago, Illinois 60602

Chicago, Illinois

September 13-18—American Electroencephalographic Society and the Society of EEG Technologists

Annual Meeting

Program will include a Symposium on Psychological Correlates of the EEG and other Symposium on Generalized vs. Focal Electroencephalographic Seizure activity.

A joint session with AEST on The Future of EEG Technology will also be included.

ASET will present a one-day course of Fundamentals of EEG Technology.

The ASET Program will feature a Round Table Discussion on Experiments in Local "Teach-ins" for EEG technologists.

For further information contact: Mrs. Margaret H. Henry, Executive Secretary, American EEG Society, 36391 Maple Grove Road, Willoughby Hills, Ohio

Hotel Radisson South, Bloomington, Minnesota

September 13-15—American Electroencephalographic Society

Continuation Course on "Clinical Electroencephalography"

This course is designed to review principal applications of EEG to clinical medical practice.

For further details or registration contact: Dr. Donald W. Klass, EEG Course Director, Mayo Clinic, Rochester, Minnesota 55901

Minneapolis, Minnesota

September 15—DuPage County Medical Society

Dinner at 7 p.m., wives invited; speaker Dr. Bergen Evans on the topic of "The Pleasures of Life." All doctors are invited, no host dinner, reservations necessary.

Holiday Inn of Oak Brook Terrace

September 17—Loyola University Social Work Alumni Association

Institute on Psychological and Legal Aspects of Child Abuse

Gustavo A. Lage, M.D., University of Illinois, Dept. of Psychiatry Clinical Assistant, Professor of Psychiatry, and Ward P. Fisher, attorney-at-law, active trial practitioner, will be featured speakers.
Mail or phone inquiries to: Miss Dorothy E. Higgins, (312) CE-6-5172 or Miss Mary Ann Chuman, Chairman Registration, (312) 842-4700, Ext. 355

McCormick Place, Room 20-8W, Chicago, Illinois

September 20-24—American Academy of Ophthalmology and Otolaryngology

Annual Meeting

For further convention details write: C. M. Koss, M.D., Executive Secretary-Treasurer, American Academy of Ophthalmology and Otolaryngology, 15 Second Street, S.W., Rochester, Minnesota 55901.

Convention Center, Las Vegas, Nevada

September 23-24 American Heart Association

Midwest Stroke Conference

An outstanding program with distinguished faculty drawn from the North Central Region of the American Heart Association. Two days of general and special interest sessions. Make all reservations early, phone (313) 965-0200.

Hotel Pontchartrain, Detroit, Michigan

September 23-25—Illinois Society of Radiologic Technologists

36th Annual Meeting
Sheraton-Oakbrook, Oakbrook Illinois

**September 26-
October 1—Flying Physician Association**

Membership in the Flying Physician Association is open to all medical doctors who hold a valid pilot's certificate.
For applications write to: Mr. Albert Carriére, Business Co-Counsel, Flying Physicians Association, 801 Green Bay Road, Lake Bluff, Illinois 60044.

Grand Hotel of Mackinac Island, Michigan

September 27-30—American Academy of Orthopaedic Surgeons Committee on Injuries

"Emergency Care and Transportation of the Sick and Injured"

Lectures, demonstrations, discussion, and class participation designed for: Ambulance attendants, firemen, policemen, emergency squads, volunteer rescue squads, also open to: nurses, safety engineers, emergency room, civil defense, industrial health, and public health personnel. Fee: $50. For advance registration contact: Marshall B. Conrad, M.D., 4960 Audubon Ave., St. Louis, Missouri 63310.

Chase Park Plaza Hotel, 212 North Kingshighway, St. Louis, Missouri

**September 30-
October 2—American Medical Association**

13th National Conference on Physicians and Schools

One evening will be devoted to a meeting of medical society representatives to discuss medical society activities related to school health. The basic purpose of this meeting will be to interchange information about problems and programs of mutual interest.

LaSalle Hotel, Chicago, Illinois

October 5-10—University of Chicago, Department of Psychology, Obstetrics and Gynecology, & Psychiatry

23rd Annual Meeting and Workshops, The Society for Clinical and Experimental Hypnosis

Requests for information about this meeting should be sent to: Mr. Claude M. Weil, Assistant Director, The University of Chicago Center for Continuing Education, 1307 East 60th Street, Chicago, Illinois 60637.

University of Chicago Center for Continuing Education

October 18-22—American College of Surgeons

57th Annual Clinical Congress

Seventeen Postgraduate Courses; more than 250 research-in-progress reports; some 46 panel discussions and symposia in general surgery and in surgical specialties; operative telecasts from the Jefferson Medical College, Philadelphia; special session in cancer, trauma, and undergraduate surgical education; "What's New in Surgery" resume; 350 scientific and industrial exhibits; major addresses by the incoming president of the college and selected guest speakers—including the new Congress feature, John H. Gibbon, Jr. Lecture; more than 90 films; seminars; special sessions of International Relations, Professional Liability, and the F.A.C.S. Self-Assessment Program.
Information on fees: Fellows of the College whose dues are paid to Dec., 1970, may register free. Non-Fellows pay $90. Doctors in the Federal Services pay $50. Initiates, members of the Candidate Group, and surgical residents register free.
Contact: Mr. T. E. McGinnis, American College of Surgeons, 55 E. Erie St., Chicago, Illinois 60611.

Atlantic City, New Jersey

(Save for reference)



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

Generic Drugs

The following new drugs have been marketed:

NEW SINGLE CHEMICAL

FUDR Cancer Chemotherapy ℞
Manufacturer: Roche
Nonproprietary name: Floxuridine
Indications: Palliative management of carcinoma
Contraindications: Poor nutritional state, depressed bone marrow function, or potentially serious infections
Dosage: 0.1 to 0.6 mg/kg./day by continuous arterial infusion
Supplied: Vials, 500 mg. sterile powder

RIFADIN Antitubercular ℞
Manufacturer: Dow
RIMACTANE
Manufacturer: CIBA
Nonproprietary name: Rifampin (USAN)
Indications: Pulmonary tuberculosis; to be used in conjunction with at least one other antituberculous drug. Treatment of asymptomatic carriers of **N. meningitidis** to eliminate meningococci from the nasopharynx
Contraindications: Previous hypersensitivity reaction to any of the rifiamycins
Dosage: Adults: 600 mg. in a single daily administration
Children: 10 to 20 mg./kg. not to exceed 600 mg./day
Supplied: Capsules, 300 mg.

DUPLICATE SINGLE PRODUCTS

BESAN-TABS Bronchodilator ℞
Manufacturer: Tutag
Nonproprietary name: Pseudoephedrine Hydrochloride
Indications: Bronchodilation, respiratory decongestion, nasal decongestion, serious otitis media with eustacian tube congestion, and mild or minor attacks of bronchial asthma
Contraindications: Idiosyncrasy to the drug
Dosage: Adults and children over 6: One tablet 3 or 4 times daily
Children 4 mos. to 6 yrs.: ½ tablet 3 or 4 times daily
Supplied: Tablets, 60 mg.

IMMUNE SERUM GLOBULIN (HUMAN)
USP Biological ℞
Manufacturer: Armour
Indications: Measle vaccination, measles (Rubeola), infectious hepatitis, post-transfusion viral hepatitis, serum hepatitis, poliomyelitis, agammaglobulinemia, hypogammaglobulinemia, German measles (Rubella) and refractory infections
Contraindications: None mentioned
Dosage: i.m., according to disease
Supplied: Vials, 2 and 10 cc

LOPRES Hypotensive ℞
Manufacturer: Tutag
Nonproprietary name: Hydralazine Hydrochloride
Indications: Hypertension
Contraindications: Hypersensitivity to hydralazine HCl, coronary artery disease and mitral valvular rheumatic heart disease
Dosage: Initial dose, 10 mg. q.i.d.
Supplied: Tablets, 10 and 50 mg.

METALEX-P Geriatric Cerebral Stimulant ℞
Manufacturer: Arnar-Stone
Nonproprietary name: Pentylenetetrazol
Indications: Symptoms of advanced age

Contraindications: Epilepsy, severe hypertension and low threshold for cortical stimulation
Dosage: One or two tsp. one half hr. before meals
Supplied: Elixir, each 5 cc. contains 100 mg.

NICOBID Vasodilators-Peripheral ℞
Manufacturer: Armour
Nonproprietary name: Nicotinic Acid (Niacin)
Indications: Conditions associated with deficient circulation
Contraindications: Idiosyncrasy to the drug and patients with arterial bleeding
Dosage: One capsule morning and evening
Supplied: Timed release capsules, 125 and 250 mg.

NORMAL SERUM ALBUMIN (HUMAN) USP 5% Biological ℞
Manufacturer: Armour
Nonproprietary name: Normal Serum Albumin (Human) USP 5%
Indications: Emergency treatment of shock due to burns, trauma, operations and infections or where shock may ensue; burns and hypoproteinemia
Contraindications: Severe anemia or cardiac failure.
Dosage: Shock and burns: Initial dose—500 to 1000 cc. i.v.
Hypoproteinemia: 1000 to 1500 cc. i.v.
Supplied: 5% solution, each cc. contains 0.5 mg. albumin

NORMAL SERUM ALBUMIN (HUMAN) USP 25% Salt Poor Biological ℞
Manufacturer: Armour
Nonproprietary name: Normal Serum Albumin (Human) USP 25% Salt Poor
Indications: Emergency treatment of shock due to burns, trauma, operations and infections or where shock may ensue; burns and hypoproteinemia
Contraindications: Severe anemia or cardiac failure
Dosage: Shock and burns: Initial dose—100-200 cc. i.v.
Hypoproteinemia: 200-300 cc. i.v.
Supplied: Vials; 20, 50 and 100 cc.; each cc. contains 0.25 gm. albumin

PERISPAN Vasodilators-Coronary ℞
Manufacturer: USV
Nonproprietary name: Pentaerythritol tetranitrate
Indications: Relief and prophylaxis of angina pectoris
Contraindications: Idiosyncrasy to the drug
Dosage: One capsule every 12 hrs. on an empty stomach
Supplied: Timed-disintegration capsules, 50 and 80 mg.

PLASMA-PLEX Biological ℞
Manufacturer: Armour
Nonproprietary name: Plasma Protein Fraction (Human) USP 5%
Indications: Emergency treatment of shock due to burns, trauma, operations and infections or where shock may ensue; burns and hypoproteinemia
Contraindications: Severe anemia or cardiac failure
Dosage: Shock: Adults—usual minimum effective dose is 250-500 cc. i.v.
Infants and small children—15 cc./lb. i.v.
Burns: Initial dose—500-1000 cc. i.v.
Hypoproteinemia: 1000-1500 cc. daily i.v.
Supplied: 5% solution, each cc. contains 0.5 mg. selected plasma proteins

TETANUS IMMUNE GLOBULIN (HUMAN) Biological ℞
Manufacturer: Armour
Nonproprietary name: Tetanus Immune Globulin (Human) (USP)
Indications: Prophylactic agent in persons whose injuries are liable to tetanus infection. In larger doses may be useful in therapy of clinical tetanus
Contraindications: None known
Dosage: Prophylaxis: Adults: 250 units i.m.
Children: 2 units /lb. i.m.
Therapy: 15-135 units/lb. i.m.
Supplied: Vials, 250 units.

COMBINATION PRODUCTS

ADILOSS TY-MED Antiobesity Preparation-Amphetamine ℞
Manufacturer: Lemmon
Composition: Methamphetamine Hydrochloride 10 mg.
Amobarbital 60 mg.
Indications: Adjunct to diet in the treatment of obesity
Contraindications: Myocardial and coronary disease, diabetes, marked hypertension and hyperthyroidism and hyperexcitable or psychotic states. Sensitivity to any of the components.
Dosage: One tablet daily on arising
Supplied: Tablets

LACRI-TUBE Eye Preparation o-t-c
Manufacturer: Allergan
Composition: White petrolatum
Mineral oil
Nonionic lanolin derivatives
Chlorobutanol 0.5%
Indications: Lubricant for inflamed eyelids
Contraindications: None known
Dosage: Small amount to affected areas as needed or as directed by physician
Supplied: Tubes, sterile ophthalmic ointment

LIVITAMIN Vitamins-Prenatal ℞
Manufacturer: SeMed

Composition:

Vitamin A Acetate	6000	USP Units
Vitamin D_2	400	USP Units
Ascorbic Acid	100	mg.
Niacinamide	20	mg.
Pyridoxine HC1	10	mg.
Pantothenic Acid	5	mg.
Thiamine Mononitrate	3	mg.
Riboflavin	3	mg.
Folic Acid	0.5	mg.
Cyanocobalamin	5	mcg.
Calcium	350	mg.
Elemental Iron	50	mg.

Indications: Vitamin and mineral supplementation during pregnancy and lactation
Dosage: 1 tablet daily, preferably after a meal or as directed by physician
Supplied: Tablets

ORAHEMA SOLU-CAPS w/Folic Acid Hematinic/Vitamin Combination ℞
Manufacturer: Sutliff & Case
Composition:

Ferrous Fumarate (Equivalent to Elemental Iron 66 mg.)	200 mg.
Zinc (as Sulfate)	1 mg.
Manganese (as Sulfate)	5 mg.
Copper (as Sulfate)	0.25 mg.
Ascorbic Acid	30 mg.
Riboflavin	1.2 mg.
Thiamine Mononitrate	1 mg.
Cyanocobalamin	1 mcg.
Folic Acid	0.5 mg.

Indications: Simple (iron deficiency) anemia
Contraindications: None mentioned
Dosage: Adults: 1 or 2 capsules after each meal
Supplied: Capsules

STUARTNATAL 1+1 Vitamins-Prenatal ℞
Manufacturer: Stuart
Composition:

Vitamin A	6000	USP units
Vitamin D	400	USP units
Vitamin C	100	mg.
Vitamin B_1	3	mg.
Vitamin B_2	3	mg.
Vitamin B_6	10	mg.
Vitamin B_{12}	5	mcg.
Niacinamide	20	mg.
Pantothenic acid	5	mg.
Folic acid	1	mg.
Iron	65	mg.
Calcium	350	mg.
Magnesium	1.67	mg.
Potassium	1.67	mg.

Indications: Vitamin and mineral supplementation during pregnancy and lactation
Contraindications: None mentioned
Dosage: One tablet daily after a meal or as directed by physician
Supplied: Tablets

ULCERINE Antispasmodic Combination ℞
Manufacturer: Bentex, Div. ICN
Composition: Each 5 cc. contains:

Bismuth ammonium citrate	120	mg.
Hyoscyamine hydrobromide	0.225	mg.
Atropine sulphate	0.019	mg.
Hyoscine hydrobromide	0.006	mg.
Rubidium hydrate	q.s.	
Ammonium hydroxide	q.s.	
Pepsin	45	mg.
Diastase	25	mg.
Potassium chloride	50	mg.

Indications: Peptic ulcer therapy
Contraindications: Glaucoma, prostatic hypertrophy or cardiac disease
Dosage: Refer to package insert
Supplied: Liquid

VERNATE GRANUCAP Nasal Decongestant ℞
Manufacturer: Tutag
Composition:

Chlorpheniramine Maleate	8 mg.
Phenylpropanolamine HC1	50 mg.
Atropine Sulfate	1/180 gr.

Indications: Relief of respiratory tract congestion and hypersecretion
Contraindications: Glaucoma, severe hypertension, prostatic hypertrophy
Dosage: Adults and children over 6: One capsule every 12 hrs.
Supplied: Capsules

NEW DOSAGE FORMS

METALEX-P Geriatric Cerebral Stimulant ℞
Manufacturer: Arnar-Stone
Nonproprietary name: Pentylenetetrazol
Indications: Symptoms of advanced age
Contraindications: Epilepsy, severe hypertension and low threshold for cortical stimulation
Dosage: One or two tablets one-half hr. before meals
Supplied: Tablets, 100 mg.

POLYSPECTRIN Liquifilm Eye Preparations ℞
Manufacturer: Allergan
Composition: Polymyxin B Sulfate 5000 units/cc.
Neomycin Sulfate 0.5%
(equiv. to 0.35 neomycin base)
Indications: Acute or chronic conjunctivitis and other superficial bacterial infections of the eye or lid
Contraindications: Hypersensitivity to any of its components
Dosage: 1 or 2 drops every 3 to 4 hrs.
Supplied: Plastic dropper bottles, 10 cc.

GENERIC DRUGS

Since an increasing number of pharmaceutical manufacturers are selling drugs on a national basis, and offering drugs under a generic name either for sale to hospitals or pharmacies, it seems advis-

able to list the marketing of such drugs under the special classification: Generic Drugs.

ATROPINE SULFATE Eye Preparation ℞
Manufacturer: Allergan
Nonproprietary name: Atropine sulfate
Indications: Mydriasis and cycloplegia for refraction, or for iris dilation and relaxation of the ciliary muscle in inflammatory conditions of the anterior uveal tract
Contraindications: Predisposition to angle closure glaucoma or children who have previously had a severe systemic reaction to atropine
Dosage: Small amount in the conjunctival sac once or twice daily or as directed by physician
Supplied: Tubes, sterile ophthalmic ointment; 0.5% and 1.0%

SCOPOLAMINE Eye Preparation ℞
Manufacturer: Allergan
Nonproprietary name: Scopolamine hydrobromide
Indications: Mydriasis and cycloplegia for refraction, or iris dilation and relaxation of the ciliary muscle
Contraindications: Hypersensitivity to any component
Dosage: Small amount in the conjunctival sac once or twice daily or as directed by physician
Supplied: Tubes, sterile ophthalmic ointment, 0.2%



report

a service of the illinois medical assistants association

"Let's Bone Up" at Fall Symposium

By Monetta Wahlberg/Kane County

One of the important educational meetings of the year is coming up. The Annual Fall Symposium of the American Association of Medical Assistants, Illinois Society, will be held September 19, at St. Charles, Illinois.

From year to year, new medical assistants are added to our membership and we are making a special effort to interest all those who have never attended an educational meeting.

The theme this year is "Let's Bone Up." Although we expect to have some fun along with the "bone" theme, you can readily see this will be a good basic topic. Included on the program of speakers are Wendell Schmidtke, M.D., and William T. Sheehy, M.D., Kane County advisors; Nina Horun, M.D., anesthesiologist in Sherman Hospital; Robert B. Lea, M.D., orthopedic specialist, Elgin; and Miss Ina Yenerich, immediate past president, American Association of Medical Assistants, Illinois Society.

If you think your medical assistant can include Saturday in her visit to our area, there are many interesting and educational extra-curricular activities available. The world famous Haeger Potteries are located a few miles north of St. Charles, in Dundee. Lee Wards, owned by General Mills, for years has been famous throughout America for its large supply of handi-craft items of every type. Their modern warehouse store is located on Rt. 31, just north of Elgin.

The 1971 Annual Symposium will be held in the Ramada Inn, Route 64, St. Charles, Illinois September 19, from 8 a.m. to 3 p.m. Registration fee is $5.00, including lectures, breakfast and luncheon. Please encourage your medical assistant to attend this worthwhile event.

If any further information is needed regarding this event or membership in this organization, please contact Mrs. Norma Domanic, 150 Ash Street, New Lennox, Illinois 60451 or Mrs. Vivian Kraft, R.R. 2, Normal, Illinois 61761.



editorials

Eat what you like

Diets, like drugs, ought to be subjected to controlled trials. This is important because in an attempt to cure the sick, many of our patients are deprived of the enjoyment of eating. Several years ago your editor asked six internists what dietary regimen they used in the treatment of irritable (spastic) bowel. There was considerable overlapping of the foods allowed and forbidden. Some recommended strict bland diets allowing chicken, fish, potatoes, macaroni, pureed spinach, green beans, and carrots. No fried foods were allowed. In addition, the individual could eat rolls, white bread, Jello, cooked peaches, plain cake and one cup of coffee in the morning with cream and sugar.

However, most of the diets were less restrictive and two of the physicians avoided diets and relied more on tinture of belladonna in elixir phenobarbital or triple bromides. In other words, all treated the disease differently even though we know that the irritable bowel syndrome has heavy emotional overtones.

During the past few years, many authorities have switched from a bland to a high-roughage diet in the treatment of diverticulosis. Justification of the change is based on studies showing that the bowel contracts harder (and pushes out diverticula) when the contents are soft and lack roughage.

Recently the dietary treatment of acne also has been sharply criticized.

Many individuals have great faith in the effects of foods on their gastrointestinal tracts. Through myth, tradition, or personal experiences, they know that certain edibles are indigestible or an allergy exists. Idiosyncrasy is a term also used in discussing the pros and cons of fruits, nuts, pickles, sausage, and black coffee.

Physicians cannot argue with an individual who claims that certain foods or combinations of foods cause indigestion even though we suspect the culprit to be the psyche and not the gastric mucosa. A British physician recently suggested that we have a national campaign to eliminate obsolete diets. Gout responds to the uricosuric drugs and the strict avoidance of gout-producing goodies is not always necessary.

The low fat diet for gallbladder disease is legendary and still recommended when the individual is overweight or has an intolerance to fats. However, fat actually empties the gallbladder and is logical to use because biliary stasis is one of the causes of the disease.

Perhaps our dietitians will now have time to deal with more specific diets, such as those used in treating diabetes, steatorrhea, disaccharidase deficiency and obesity. Many physicians also are becoming connoisseurs of fine cuisine and wines. They might bring a bit of joy into the lives of their patients by encouraging them to consume the pleasures of the table.

T. R. Van Dellen, M.D.
Editor

QUO VADIS, M.D.

As a practitioner and educator in medicine for almost forty years, I have been deeply disturbed during the past years by the trend in medical education and practice towards narrow specialization and loss of interest in dealing with patients as whole human beings. While there is obviously a need for specialization due to the great expansion of medical knowledge and procedures, there is also a still greater need for preserving the skill of the old-style clinicians, whether they be called general practitioners or family doctors, who could deal with the mani-

Quo Vadis, M.D.

fold human ills in a comprehensive and sympathetic way. Broad medical knowledge was frequently achieved in prior years by the fact that subspecialty boards would accept candidates only after they had clinical experience in general medical practice for some years.

While I am a subspecialty diplomate and have been closely associated with clinical and science departments in a large city hospital, I nevertheless consider myself a physician first, and see in my limited practice, various types of patients, some of whom I obviously refer to other colleagues when there is a need for more specialized care in certain fields. To me internal medicine is like family practice except that the internist does not do surgery or obstetrics.

Unfortunately, my opinion of the practice of internal medicine is now difficult to implant into the younger men, who are trained, starting with the medical school and later in some "teaching" hospitals to limit themselves to certain areas. This teaching, official or by precept, results in many fine young people entering the medical field with wrong attitudes and at times, wrong values. This early specialization and even subspecialization has resulted in some of our fine house staff members being unable to perform a good and thorough physical examination and to present a good clinical discussion of the presented case, as evident by the high failure percentage during the oral board examinations. These candidates can excellently discuss a single or special problem which falls in the area of their special interest, but frequently cannot evaluate the presenting patient as a sick human being.

The present trend by medical students and the house staff in getting into their areas of interest as soon as possible prevents them from becoming persons with broad knowledge. This is emphasized also by the fact that many young people now prefer spending their time in libraries reading, rather than at the bedside of the patient. Many young people have not been taught the value of learning at the bedside during rounds with clinical teachers, when both old clinical skills and new scientific methods can be applied in a broad approach to the problem of the presenting patient.

This state of present medical education seems to be disturbing to even some of the young people, as witness the following quotations from a recent letter of a medical student in the *New England Journal of Medicine* (Feb. 25, 1971): "I am sorry to have to make this prediction, but if my perception of the overall handling of medical students at my own school and other medical institutions with which I am familiar is accurate, I can forsee a deterioration in medical care that will become evident within the next decade, as present graduates replace the superstars of medicine—namely, the vanguards of a passing era, who were treated as students in the strict manner appropriate to a physician-in-training, and who subsequently incorporated that strictness and devotion into their life styles. . . . From what I have seen, both administration and faculty have become lax in terms of attitudes toward students . . . medical students who, after all, are doctors first and foremost, are being granted too much liberty in terms of time that they are not spending in developing their minds in either clinical or research medicine. . . . In the life and death field of medicine, time lost in the learning process inevitably leads to the endangering of some patient's life at a future date. It simply cannot be tolerated if we are going to turn out topnotch physicians. As for the clinical years, each year fewer and fewer nights on call are required of third and fourth-year students. Some of these students (though precious few), granted, are spending their spare time reading medicine or remaining on the wards learning what is important, but in the main they are cultivating lazy, and even, immoral habits."

The young doctor should be trained in the broad approach to the sick patient, before starting specialization. Sick people want doctors who look at them as whole human beings, and not as an anatomical part of the body. Such training can often be better obtained from clinicians who have been both practitioners and investigators, and who have learned to apply the modern technological advances in the broad field of medicine.

In *Modern Medicine* (August 24, 1970), Walter C. Alvarez writes: "I have often thought that if I were dean of a medical school, I would try to get an old practitioner of medicine, past 65, to come in every so often, and talk to the students about the many diagnoses which for all their days they would have to make from a glance at the patient, and from perhaps the answers to a couple of questions. If I had a grandson going into medicine I would love to have

him receive much of his training from a wise 'old-timer' like Sir James Mackenzie. In the College of Law of the University of California, all the teachers are able lawyers who were acquired as professors only after they had been retired somewhere at the age of 65 The idea seems to have worked perfectly, and a bit of that could work very well in a medical school, perhaps especially in a department designed especially for the training of the today much-needed family physicians."

In *Hospital Practice* (September, 1969), we find Dr. Nicholas J. Pisacano saying "Medical faculties in general have little sensitivity to how medicine is practiced in the real world, yet they are quick with answers for practitioners. Why do we continue to educate young doctors by showing them only the one patient, of every 250 who sees a doctor, who ends up in a university hospital? Comprehensive medicine is hard to find in a medical school. Family practitioners should have an active role in the planning of education and in teaching."

Dr. Robert H. Moser, chief of the department of medicine, Walter Reed General Hospital, lashed "the staggering curriculum" which, with its emphasis on basic sciences, is so all-consuming that students "barely have time to look up from their books and laboratory benches to see the patient. Some tend to regard the patient with baleful disdain as a vessel for interesting pathology."

Dr. James B. Donaldson, associate dean and professor of medicine, Temple University School of Medicine, stated the medical graduate is statistically oriented, a computer, and observed "in no way do I wish to indict the young physician of today. He has not been properly oriented to the humanistic aspects of medicine on an equal basis with the scientific."

Dr. James L. Dennis, medical dean and vice-president of the University of Oklahoma believes that "there is an urgent need to produce the type of manpower needed." Ninety per cent of medical school graduates enter specialties, where 90% of the deficits are in primary health care, and it is in this latter area that the health care system of the nation is breaking down. The family unit is the primary unit, and the genesis of most health problems can be related to the family environment. He believes, that to cure sick families, which produce sick neighborhoods, the new science of family medicine should be utilized.

The superficiality and narrowness of clinical evaluation of the patient, and the indifference to clinical care unfortunately, does not end with some doctors at the finish of their training period, but continues with them into their practices. This is one of the reasons why some of the population have lost their love, admiration and respect for the doctor and have assumed a rather militant, hostile and at times, hateful attitude toward the medical profession. It is the great shortage of doctors that keeps many of such doctors still in active practice, despite the fact that many of their patients have little confidence or love for them. These patients simply cannot get other medical care and therefore must stick with what they have. Occasionally one is gratified to hear good reports from the patient about the doctor to whom he was referred, but more often the opposite is heard. One often dreads to refer patients to some other colleagues, because of the frequency with which they report that they are dissatisfied, are not given sufficient time, are not carefully examined, and are not clearly advised as to therapy.

It is distressing to a patient to call for an appointment and be told by the nurse that there is no opening for four to eight weeks. A patient who develops a sudden pain or health anxiety of sufficient intensity to make him promptly call a doctor, should be seen even if it makes that doctor late for a meeting or for his dinner. At times, merely talking to the patient on the phone might alleviate his symptoms or anxiety.

Whether in response to the above or whether as a result of the present militancy and irreverence to all types of status, the doctor has lost much of his altitude on the proverbial pedestal. It is hoped, and physicians should strive, for a return to their high level of patient acceptance by rededicating themselves to the idea of becoming doctors first, and specialists second. Caring for the sick individual as a whole person, one should always take into consideration his environment, his family, and his social status as well.

Some recent expression (*Medical Center News*, March, 1971) by medical educators, e.g., Dr. Bogdanoff, head of the Department of Medicine in the Abraham Lincoln School of Medicine "that one of his important tasks will be to gear the department's activities to respond to the needs and requirements of the community at large and that he is aware of the importance of psychological, social and emotional interactions with patients," may bode promise that my above expressed hope for physicians to become doctors in the broad sense of patient expectations may still come to fruition in the not too distant future.

Frederick Steigmann, M.D.



medical legal review

A review of hepatitis legislation

In the November, 1970 issue of the *Illinois Medical Journal* it was pointed out that the Supreme Court of Illinois had handed down a decision in the case of *Cunningham vs. MacNeal Memorial Hospital* which held that the hospital was liable in damages to a patient who had contracted hepatitis from a blood transfusion and that this decision would apply to everyone in any way handling the blood, including the physician.

As a result of this decision, ISMS caused to be introduced in the 1971 Session of the General Assembly, House Bill 016, which has been passed and signed into law by the Governor.

Under the terms of this Act, the procuring, furnishing, donating, processing, distributing or using human whole blood, plasma, blood products, blood derivatives and products, corneas, bones, or organs or other human tissue for the purpose of injecting, transfusing or transplanting any of them in the human body is declared to be the rendition of a service, and no warranties of any kind or description nor strict tort liability shall be applicable thereto. This statement is qualified by the provision that all persons handling the blood, including the physician, must exercise due care and follow professional standards according to the then current standards of the medical arts if liability is to be avoided.

It was the feeling of the Legislature that this immunity should only be given for a short period of time in order to encourage further research so that a reliable test might be developed to determine the presence of hepatitis in the blood and therefore, this entire Act is repealed on July 1, 1973.

While we feel that this Act provides the desired immunity until July 1, 1973, in order to provide maximum protection, it is recommended that the consent form (below) continue to be used.

REQUEST FOR TRANSFUSION OF WHOLE BLOOD OR ANY OF ITS COMPONENTS

I, ..., do hereby request Dr. and any of his assistants
(Attending Physician)
or associates (hereinafter called physician) to administer to me such blood transfusions or any blood components including, but not limited to, plasma, as may be deemed advisable in the judgement of any such physician.

It has been explained to me that it is not always possible to detect the existence or non-existence of some elements occasionally present in blood such as the virus causing infectious hepatitis or other unusual blood components and that there is a possibility of ill effects, such as Infectious Hepatitis resulting from the transmission of its virus or a transfusion reaction resulting from the transmission of unusual blood components. I also understand that there is the possibility of the transmission of the causative agent of other diseases.

It has also been explained to me that emergencies may arise when it is not possible to make adequate cross-matching or other tests and that immediate need may make it necessary to use existing stocks of blood which may include some incompatible blood types or substances.

It is understood and expressly agreed that the blood supplied in accordance with this agreement is incidental to the rendition of services and that no requirements, guarantee or warranty of fitness, quality or absence of undetectable substances such as viruses shall apply.

After considering all of the items set forth above and the possibility of adverse results from the said blood transfusions, it is still my desire that one or more transfusions of blood or its components be administered to me, if in the opinion of my physician such transfusions are needed.

I hereby assume any and all risks in connection with any said blood transfusions and release physician and Hospital of, Illinois, its personnel and employees, all blood donors and all other persons, firms and corporations which in any way handled or processed said blood, from any responsibility whatsoever for any resulting contraction of viral hepatitis or any reaction from any such transfusion.

I further assume any and all risks in connection with said blood transfusions and agree that I will never bring suit in connection with said transfusions.

IN WITNESS WHEREOF I have hereunto set my hand and seal at M. on this the day of, A.D. 19.....

..... (Seal)

STATE OF ILLINOIS)
) SS
COUNTY OF)

I, ..., a Notary Public in and for said County in the State aforesaid, do hereby certify that personally known to me to be the same person whose name is subscribed to the foregoing instrument, appeared before me this day in person, and acknowledged that he signed, sealed and delivered the said instrument as his free and voluntary act for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this day of, A.D. 19.....

.....
Notary Public

APPROVED **AVAILABLE NOW!**
ISMS
MALPRACTICE INSURANCE

Professional Liability Insurance Program
Approved for Members
REGARDLESS of AGE or SPECIALTY

Protect Doctor's Integrity
Company will settle no claims without insured member's approval. Nuisance claims *will* be fought.

Improve Legal Climate
Company will retain outstanding defense counsels who are experts in professional-liability cases.

Provide Market Stability
Company will maintain an available market. Participation by the members is needed to assure this market.

Keep Members Informed
Company will tell members how to prevent claims . . . keep them aware of latest legal developments in malpractice field.

ISMS Supervision And Control
Premiums to reflect only the loss experience of ISMS. All questionable underwriting cases to be reviewed by ISMS. A UNIQUE FEATURE

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT ADMINISTRATORS:

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

viewbox

(Continued from page 121)

DIAGNOSIS: *Neurofibroma.* The PA chest demonstrates a well-defined, circumscribed density which does not obliterate the right heart border, therefore placing the lesion in a posterior location (see lateral). The smooth contour suggests that it is extrapleural in character which would locate it within the contents of the mediastinum. The posterior mediastinal compartment lies between the pericardium and the anterior aspect of the vertebral column. It is a frequent site of neurogenic neoplasms. Those which arise from peripheral nerves are neurofibromas and neurilemmomas. Neurofibromas are derived from the endoneural tissue. Mediastinal neurofibromas may be associated with generalized neurofibromatosis.

Roentgenographically, the appearance of all neurogenic neoplasms is similar. They are sharply circumscribed, oval, and of homogeneous density, and may be in the paravertebral zone of either side. Calcification is occasionally present. The ribs or vertebrae may sometimes be eroded by both benign and malignant neoplasms. A neurofibroma that originates in a nerve root within the spinal canal may be shaped like a dumb-bell or hourglass, part being inside and part being outside the spinal canal; in such circumstances the intervertebral foramina may be expanded.

ekg of the month

(Continued from page 125)

ANSWER:

B. True Posterior wall myocardial infarction, probably old. Pathologic Q waves, the hallmark of myocardial infarction, are absent in the conventional 12-lead electrocardiogram unless either inferior or lateral myocardial infarction co-exists. Abnormally tall and/or broad R waves are present in lead V_1. The R/S ratio is 1.0 or greater in leads V_1 and V_2. The T waves are upright and tall in V_1, V_2 and V_3. The differential diagnosis includes right ventricular hypertrophy usually associated with right axis deviation and ST-T changes, RBBB with QRS complexes and prolonged to 0.12 or more seconds and pre-excitation syndrome (W-P-W) with short PR interval and delta waves on the upstroke of R wave.

The review of patient's previous hospitalization revealed diagnostic rises in serum enzymes. Selective coronary arteriography showed significant obstruction of the branches of right coronary and left circumflex arteries.

Peer review in cancer

(Continued from page 136)

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Film depicts uses Of human blood derivatives

"Precious Tissue," a new film on the therapeutic uses of human blood derivatives, is now available for physicians and other medical professional group showings.

Produced as a service for the American National Red Cross by Armour Pharmaceutical Company, the film depicts actual hospital cases pointing out the benefits of administering human blood components rather than whole blood or plasma.

The 16 mm, sound, color film runs approximately 11 minutes. Requests for a free loan should be directed to Professional Services, Armour Pharmaceutical Company, Box 1022, Chicago 60690.

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REGISTERED AIA MEDIA DATA FORM



Amid all the clamor about coexisting anxiety and depression



BLUE SHIELD REPORT FOR Illinois Physicians

Requirements for Diagnostic, Dental Benefits Clarified

In 1970, the Blue Shield Plan of Illinois Medical Service paid over 52 million dollars in benefits for services received by our subscribers from physicians in Illinois and in other states and foreign countries. This was an increase of almost 25 percent over the dollar amount paid in 1969. Close to 10 percent of these benefits were paid under the Federal Employee Program which, with over 5 million members enrolled nationally, is the largest single group ever covered by Blue Shield.

The increased volume of claims received by Blue Shield, especially for diagnostic services for Federal Employee Program (FEP) members, increases the necessity for complete and accurate information concerning services rendered to our members. The following clarifications on information requirements and limitations of coverage for specific services provided to Blue Shield members, in general, and Federal Employee Program members, in particular, should help physicians in supplying the information necessary for the prompt processing of claims.

1. Complete diagnosis information is required on claims for outpatient x-ray and laboratory services. Most contracts exclude routine diagnostic examinations such as routine chest x-rays and pap smears.

2. Claims for diagnostic services must indicate whether the services were performed in the physician's office or in an outside laboratory. If the services were performed in an outside laboratory, the laboratory must be identified.

3. Admissions for x-ray, laboratory . . . or other studies are excluded from the FEP and nearly all Blue Shield contracts. Hospital stays during which the treatment and/or diagnostic procedure were all such that could have been and often are safely performed outside the hospital will have to be disallowed. FEP will no longer pay for diagnostic admissions under the FEP Supplemental Benefits.

4. Hospital care must be medically necessary in order for inpatient benefits to be paid. Questionable diagnoses will be reviewed by our Medical Department and the physician may be asked more frequently to supply additional information.

5. No benefits are available under any contract for custodial care.

6. All dental admissions require certification based on dental admission criteria. This criteria varies from group to group.

Under FEP, Blue Shield benefits can be paid to a doctor of medicine (M.D.), a doctor of dental surgery (DDS), or a doctor of dental medicine (DMD) for any of the following oral surgical procedures:

The surgical removal of impacted teeth.

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when such conditions require a pathological examination.

Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of mouth when such injuries have occurred while the member is covered under the plan.

Excision of exostoses of the jaw and hard palate.

Treatment of fractures of facial bones.

External incision and drainage of cellulitis.

Incision of accessory sinuses, salivary glands or ducts.

Reduction of dislocations of and excision of temporomandibular joints.

The following surgical procedures are specifically *excluded*:

Surgery of the teeth (except removal of impacted teeth), structures supporting the teeth, and gingival tissues; and alveolar processes.

7. Under FEP, *physician rendered* inpatient physical therapy is a covered basic service if it is determined that hospitalization is required. If the related hospitalization is determined to be *unnecessary*, such physician rendered physical therapy is to be covered under the Supplemental Benefits. Physical therapy rendered by a person other than an M.D. is not covered under basic benefits but may be covered under the Supplemental Benefits.

8. No payment will be made under any contract for claims where obesity is the primary diagnosis. Questionable diagnoses will be reviewed.

9. For claims involving injuries, occupational diseases, or other diagnoses where compensation under the Workman's Compensation Act of the Federal Employee's Compensation Act may be available, the eligibility of the patient for such compensation must be obtained before the claim can be processed.

(This is not an advertisement)

ASK BLUE SHIELD
• • • ABOUT MEDICARE

Physical Therapy Coverage Under Medicare

Recent changes in Medicare regulations by the Social Security Administration further define the eligibility of physical therapy services. In order for benefits to be available under the Medicare program for physical therapy services, the following conditions must be met:

1. The services must be directly and specifically related to an active *written* treatment regimen designed by the physician after any needed consultation with the physical therapist;

2. The services must be of such a level of complexity or sophistication or the condition of the patient must be such that the judgement, knowledge and skills of a qualified physical therapist are required;

3. The services must be performed by or under the supervision of a qualified physical therapist;

4. The service must be expected to improve significantly the patient's condition in a reasonable period of time or to be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease trait;

5. The service must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition; and

6. The service must be necessary and reasonable for the treatment of the patient's condition.

Services provided for the general good and welfare of the patient such as general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation are *not* eligible for benefits.

Restorative Therapy. As indicated above, the physical therapy service furnished an individual must be reasonable and necessary to his course of treatment. If an individual's expected restoration potential would be insignificant to the extent and duration of physical therapy services required to achieve that potential, the physical therapy would not be considered reasonable and necessary to the treatment of the individual's illness or injury. Therefore, here must be a medically appropriate expectation that the patient's condition will improve significantly in a reasonable, and generally predictable, period of time based on the assessment made by the physician of the patient's restorative potential after any needed consultation with the physical therapist. Since such expectations may not always prove valid, the realization that restoration will not occur should also be reached in a reasonable, and generally predictable, period of time.

Maintenance Therapy. In most cases, the repetitive services required to maintain function do not require complex physical therapy procedures and, therefore, the judgment and skill of a qualified physical therapist are not required for the safe and effective performance of such services. However, in some cases, as for a Parkinson patient, the judgment and skill of a qualified physical therapist are needed to establish a maintenance program if the program is to be safely carried out and the treatment aims of the physician are to be achieved. In such situations, the initial evaluation of the patient's needs, the designing by a qualified physical therapist of a medically appropriate maintenance program, the instruction of the patient or family members in the carrying out of such program, and such infrequent reevaluations as may be required would be considered eligible physical therapy services.

Physical therapy services are reimbursable under Medicare when rendered in the outpatient department of participating hospitals, extended care facilities and home health agencies. Benefits may also be paid for outpatient physical therapy services rendered at approved clinics, rehabilitation centers, and public health centers when these facilities meet certain requirements.

Certification and Treatment Plan

Besides listing the above requirements, the Medicare regulations state that a physician's certification is needed before payment for physical therapy services can be made.

The physician's certification should indicate that:

1. The physical therapy services are or were required by the patient on an outpatient basis;

2. A plan for furnishing such service is or was established and periodically reviewed by the physician; and

3. The outpatient physical therapy services are or were furnished while the patient is under the care of a physician.

Since certification is closely associated with the plan of treatment, the same physician who established the plan must certify to the necessity for outpatient physical therapy service. Certification should be obtained at the same time the plan of treatment is established or as soon thereafter as possible.

When outpatient physical therapy services are continued under the same plan of treatment for an extended period of time, the physician must recertify at intervals of at least once every 30 days that there is a continuing need for such services and should estimate how long service will be needed. Recertification should be made at the same time that the plan of treatment is reviewed and must be signed by the physician who reviews the plan of treatment.

The plan of treatment, established in writing before treatment is begun, must relate the type, amount, frequency and duration of the proposed physical therapy services and must indicate the diagnosis and anticipated goals. The plan must be reviewed by the physician in consultation with the physical therapist at least once every 30 days. The plan need not be submitted to the Medicare carrier but should be kept with the patient's records. When billing Medicare, the provider should certify that such a plan is on file.

(This is not an advertisement)

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the presidents page

"Physician, heal thyself!"

Nobody can solve all of today's health care problems over-night, and nobody knows it better than we physicians.

But too often we remain silent while federal bureaucrats, national labor leaders and other misguided health care seers are busy promoting socialized medicine.

I suggest we speak out to our patients, to our hometown newspapers, to civic clubs, and to anyone else who will listen. Let's get involved, and let's begin in our own home communities.

Too often we bury ourselves in our practices and fail to study the problem and suggest solutions. Too often we are complacent and abdicate to unqualified personnel our duty and our commitment to plan for the future.

Too many of us refuse to take the time and the effort to participate in governmental affairs —yet these same physicians are the first to criticize and complain when they don't like the results achieved by others.

We have a vital stake in what's happening in our state legislature.

Organized medicine was very successful during the past session of the General Assembly in suggesting and supporting measures to improve health care delivery in Illinois. We instigated legislation to put more young people into medical schools; we supported legislation designed to increase the physician population of Illinois by eliminating the U.S. citizenship requirement for licensure, thereby making it possible for qualified foreign doctors to practice in our state; we supported the "Sick Doctor" legislation giving the Department of Registration and Education the authority to suspend a physician's license when he practices "bad medicine" due to emotional or other problems; we supported legislation encouraging local areas to become active in health planning; and we supported appropriations bills which increased state financial aid to public and private medical schools.

But the session is not over . . . and some ideas not compatible with what we seek for the people of Illinois are still pending in the legislature.

Are you aware that legislation is pending which would give the Director of the Department of Public Health dictatorial power in deciding when and where hospitals may be established, new medical services added to existing hospitals and facilities renovated?

Are you aware of the bill which would permit non-medical personnel to tap the keg of medical health insurance policies, increasing "health" costs even more?

Are you aware that optometrists want government to mandate separate eye exams by optometrists (or ophthalmologists) for school children entering kindergarten or first, fifth and ninth grades? Think what this will do to the "health" care dollar!

You should be aware of such bills and accept the challenge of solving the problems facing us today!

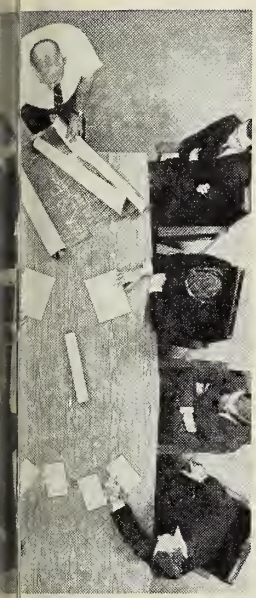
What is the challenge? Get involved! Learn what's happening in state and national government. Contact your legislators and other elected officials to let them know you're concerned. Contact our Chicago or Springfield office and ask to be placed on the mailing list for *On the Legislative Scene.*

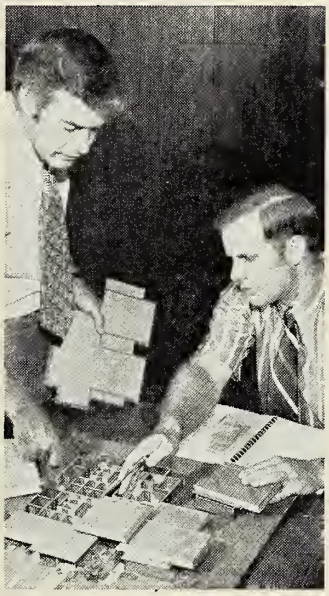
The Prophet once commanded: "Physician, heal thyself!" It's about time we paid heed to His words.

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membership forum

The FDA and physicians

In an editorial, "Combination drugs: A therapeutic tool," which appeared in the June, 1971, issue of the *IMJ*, Dr. Frederick Steigmann suggested the FDA change its intent of prompt removal of combination drugs from the market, since "A sudden removal of useful and time-tested combination of drugs from the therapeutic armamentarium of the practicing physician will not help the patient and will limit the therapeutic effectiveness of the doctor."

Following is a reply from the Department of Health, Education and Welfare's Commissioner of Food and Drugs. (Dr. Steigmann is chairman, Therapeutics Committee, Department of Gastroenterology, Cook County Hospital, and chairman, *IMJ* Editorial Board.)

June 8, 1971

Dear Dr. Steigmann:

Thank you for your letter of April 12, 1971 commenting on our proposed policy on combination drugs.

For a variety of reasons, there has been widespread misunderstanding about the FDA policy on combination drugs. To correct this and to be helpful, we want to explain our combination drug policy to you.

As we review the several hundred physician letters that have come to us objecting to the proposed policy, a number of themes emerge.

The first is that drug combinations should not be banned by an across-the-board policy statement. We agree.

Second is the assertion that many drug combinations are safe and effective for their intended uses, while others are not. We agree with this, too.

Third, the point is made that the practicing physician has not been consulted adequately; that the practicing physician is the one who knows best about drug effectiveness from his daily observations with his patients; and that the policy proposed is a product of "ivory tower" thinking of bureaucrats or academicians out of touch with the realities of patient care. Actually, we did consult with many knowledgeable practicing physicians before proposing this policy. We now have heard from a great many other physicians, and we are considering all views. Most would agree that drug effectiveness has to be evaluated on the basis of controlled studies, whether they be carried out in the physician's practice or in a medical center. What we ask and what the law requires is that claims of effectiveness be supported by evidence derived from adequate clinical investigations on the basis of which it can be concluded responsibly that any drug will have the effectiveness it is represented to have and which it purports to possess.

The next major objection is that the policy we propose will greatly increase patient cost and will confound both prescribers and pharmacists in prescribing and in compounding drug mixtures. The last is said to introduce problems of quality control, drug compatibility, and patient acceptance of needed medicines. None of these is a reality. If a drug combination is medically justified, there is no reason why it should not continue to be available from the pharmaceutical manufacturers. If it cannot meet reasonable

(Continued on page 249)

IMJ
Illinois Medical Journal

Amniography in the early diagnosis of molar pregnancy

By Irving Weissman, M.D., F.A.C.R. and Lewis Trupin, M.D./Urbana

THE EARLY DIAGNOSIS of hydatidiform mole is essential since it is basically a degenerative process with a definite neoplastic potential. Clinical behavior as well as laboratory data may be confusing. Sanders[1] states that it is of fundamental importance that 10% of hydatidiform moles are complicated by some degree of malignant change and that 50% of chariocarcinomas are preceded by hydatidiform moles. Early diagnosis allows early termination of the abnormal pregnancy and later complications of hemorrhage, subsequent cancer or early toxemia. It is the purpose of this paper to present a radiographic method for early detection of molar pregnancy with considerable accuracy and with little risk to the patient. It is not a new technique, but appears primarily in the foreign literature,[1,3-5] apparently because the disease is more prevalent in Asia and Africa.

The technique of amniography was first employed by Menees, Miller and Holly[2] in 1930, for placental localization. In 1955, Borell and Fernstrom,[3] in Sweden, first described its useful application in the diagnosis of hydatidiform mole. The procedure is considered simple, safe and carries a high level of accuracy. The patient is prepared first by catherization of the urinary bladder. An 18 gauge spinal needle is introduced transabdominally at a point in the midline, three to five centimeters below the umbilicus until it is considered to be inside the uterine cavity. Following aspiration, rapid injection of 20 to 50 cc. of 50% Hypaque is carried out. A.P. and lateral roentgenograms are taken within five minutes following injection. The X-ray findings are conclusive, showing the enlarged uterine cavity containing a honey-comb or moth-eaten

Amniograph and molar pregnancy

appearance caused by the contrast medium filling the intervesicular spaces and this may be partially obscured by the layering affect of the medium. The procedure causes no significant reaction. This is true in the case presented here and is confirmed by the many cases reported in the literature.[4-6]

Case Report:

L.H. is a 27-year-old white female, primagravida, first seen on June 26, 1970, complaining of vaginal bleeding of three months duration. Her last normal period was on January 20, 1970. She was followed elsewhere as a threatened abortion and was treated with Provest, vitamins and bed rest. Physical examination revealed an enlarged uterus of about five months gestation. There were no fetal heart tones and the patient never felt the baby move. Blood pressure was 180/100. X-ray of the abdomen showed a good size pelvic mass extending to the level of the fifth lumbar body consistent with an enlarged uterus and containing no evidence of a fetal skeleton (Fig. 1). A U.C.G. titer was reported extremely high for the stage of pregnancy. Chest X-ray was normal. On June 30, 1970, amniography was performed. An 18 gauge needle was inserted transabdominally approximately five centimeters below umbilicus and 30 cc. of Hypaque injected after failure to aspirate amniotic fluid. X-rays of the abdomen taken A.P. and laterally (Figs. 2 & 3) confirmed a typical honeycomb or lace-like mass in the pelvis diagnostic of molar pregnancy. Curettage and suction produced 1.5 liters of molar tissue. The pathological report was benign mole. Recovery was complete and patient has had regular menses on birth control pills.



Fig. 1. Abdomen: Large pelvic mass, showing no evidence of fetal skeleton.

Discussion

Hydatidiform mole is a complication of pregnancy characterized by abnormal trophoblastic proliferations of chorionic villi deprived of fetal vascular circulation. Hertig[7] states the cysts begin to form the third to fifth developmental week when feto-chorionic circulation normally becomes established. Since the fetus is defective or absent, no chorionic circulation develops, re-



IRVING WEISSMAN, M.D., F.A.C.R., (left) is radiologist in charge at Mercy Hospital, and consulting radiologist at McKinley Hospital in Urbana. He also maintains a private practice in radiology. Dr. Weissman is a Diplomate of the American Board of Radiology and a Fellow of the American College of Radiology.

LEWIS TRUPIN, M.D., (right) maintains a private practice in obstetrics-gynecology, and is on the staff of Mercy Hospital in Urbana, Department of OB-GYN. He received his M.D. degree from New York Medical College and is a Fellow of the American College of OB-GYN, and a Diplomate of the American Board of OB-GYN.

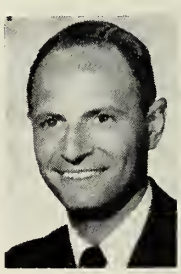




Fig. 2. Abdomen, following amniocentesis and Hypaque injection—shows large honey-comb and moth eaten appearance of uterus diagnostic of hydatidiform mole.

sulting in the dissolution of the mesodermic core. The trophoblast, nourished by maternal blood in the intervillous spaces, continues to live and absorb substances into the villi, converting them into cysts and explaining the rising titer of chorionic gonadatropins. The emphasis is on early diagnosis because of the potential progression into trophoblastic malignancy. Zarou, et al.[4] report a case in which molar pregnancy was confirmed by amniography, but a chest X-ray revealed pulmonary metastases and pathology reported choriocarcinoma following curettage. Cheng,[5] from the University of Singapore, reported benign mole in ten out of 11 cases in his series. The one case was a normal pregnancy confirmed by amniography with a normal fetus ultimately delivered.

In America and Europe, benign hydatidiform mole occurs at an estimated rate of one in 2500 pregnancies, while in Asia and Africa, it is ten times more frequent.

Conclusion

A case of molar pregnancy is reported and diagnosed accurately by amniocentesis and amniography. The technique is described and advocated as an early, safe and accurate diagnostic procedure to avoid the hazard of malignant degeneration. A review of the literature confirms these opinions. ◄

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Fig. 3. Abdomen: (Lateral View) Confirming hydatidiform mole following amniography.

Abstracts of Board actions

Board of Trustees Meetings
Regency Hyatt House, Chicago
July 17-18, 1971

1972 ANNUAL MEETING PROCEDURES

Preliminary plans for the 1972 annual meeting, which will be conducted with the Chicago Medical Society's Clinical Conference March 7-11, have been approved by the Board. Because the meeting has been advanced from its traditional May date, certain procedural changes are necessary. The *Delegates Handbook* will be pre-printed and mailed to delegates, alternates and county society officers prior to its appearance in the February issue of the *Illinois Medical Journal.* Reference Committee chairmen will be appointed in December.

In a related action, the Board of Trustees named the chairmen of the Reference Committees from the 1971 House to serve as an Ad Hoc Committee to study House of Delegates procedures. Among the items to be considered are a cut-off date for submission of resolutions, a referendum approach to seeking constituent medical society opinion on matters related to the private practice of medicine, and the use of resolutions for acting on policy matters.

STATEWIDE COUNCIL ON CONTINUING MEDICAL EDUCATION

Dr. Edward W. Cannady has been appointed chairman of an ad hoc committee to organize an independent statewide council on continuing medical education. ISMS participation and initial funding for the organization had been approved by the 1971 House of Delegates. Other members of the ad hoc committee are Drs. Dean Bordeaux, Herschel Browns, and Jack Gibbs, with Immediate Past President, J. Ernest Breed, as consultant.

EMERGENCY ROOM IMMUNITY

The Board has instructed the Governmental Affairs Council to develop legislation that would provide immunity for emergency room personnel. The move results from legal action recently taken against a physician performing emergency procedures outside his specialty.

REVISED 1971 BUDGET APPROVED

The Board has approved a revised budget for 1971. Revisions consist of minor shifting of line items; no changes in total receipts and expenditures were made in the original budget presented to the House of Delegates in May.

ADVERTISING INCOMES

The Publications Committee, having expressed concern about future advertising revenues has been authorized to:

1. Accept appropriate commercial advertising in the *Illinois Medical Journal,* provided that such advertising is in good taste and of use or benefit to the membership.
2. Increase *Journal* advertising rates by 10% January 1, (except for four-color work, which will remain unchanged) and modify preferred position rates to cover anticipated printing and production costs.

TASK FORCE ON PHYSICIAN SHORTAGE

To decentralize medical practice throughout the state, the Board has approved the following recommendations:

1. The Health Education Commission of the Board of Higher Education should conduct a motivational study to determine what factors might be effective in persuading physicians to practice in medically deprived areas.
2. The University of Illinois and its component schools should formally accept affiliation with community hospitals on a pilot basis to establish residency programs in rural areas.
3. The Council on Education and Manpower and the ISMS Task Force on Physician Shortage should meet with other medical school deans to consider the feasibility of a "Community Hospital Residency" and to offer assistance in developing a curriculum.
4. The ISMS Public Relations Division should initiate an educational campaign aimed at educating communities throughout the state on what they can do to attract health personnel.
5. ISMS should call on medical schools to recognize participation in MECO as credit toward accomplishing extramural training, with such participation entered on the student's record. The ISMS Public Relations Division should develop a continuing promotional program to encourage additional hospitals to participate in the MECO program.

CONSUMERS ORGANIZATION AGAINST CHIROPRACTIC

The Board has approved in principle a proposed consumers organization of groups which have issued policy statements relative to chiropractic. The ISMS Licensure Committee was instructed to develop a proposed structure for such an organization.

NURSE REVIEW OF PSYCHIATRIC CHARTS

On recommendation of the Council on Mental Health and Addiction, the Board will ask Blue Cross and Blue Shield to explain their procedure for reviewing psychiatric charts and suggest that any chart reviewed by a nurse have a subsequent review by a psychiatrist.

HEALTH CARE FINANCING

The Board will request the Illinois Department of Public Aid to pay a minimum of $50 for physicians assisting at major operations. The present minimum rate is $25. Additional payment is made for lengthy operations.

SICKLE CELL ANEMIA

On recommendation of the Council on Governmental Affairs, an ad hoc committee was appointed to study the problem of sickle cell anemia, especially in regard to proposed legislation requiring mandatory screening for the disease in schools and in pre-marital examinations. The committee will be asked to report back to the Governmental Affairs Council in September.

USE OF CHICAGO STATE TUBERCULOSIS SANITARIUM

Governor Ogilvie has been asked to transfer the physical plant of the Chicago State Tuberculosis Sanitarium from the Public Health Department to the University of Illinois, to house legislatively-approved projects awaiting suitable space.

The building, which will no longer be used for T.B., can be converted almost immediately to needed uses in medical education, medical care, drug abuse, alcoholic therapy and other services. The Sanitarium is located within the confines of the University of Illinois Medical Center Complex.

Abstracts of Board actions

ASK GOVERNOR NOT TO CURTAIL IMMUNIZATION PROGRAM

Believing that additional cuts in the Department of Public Health budget will mean curtailment in its preventive medicine program, the Board has requested the Governor to assure that no prophylactic preventive programs in infectious diseases, such as diphtheria, tetanus, pertussis, V.D., measles, poliomyelitis, German measles, mumps, and smallpox be abolished.

The Board also requested that final authority on all health rest with the Director of Public Health and offered the services of its committees and staff to assist in any plans for improving the health of the citizens of Illinois.

LICENSING STANDARDS FOR AMBULATORY CENTERS

The following have been recommended for positions on a special committee on the development of standards for ambulatory centers, such as abortion clinics, inhalation therapy clinics, surgicenters, etc.; Drs. Theodore Balsam (Chicago); C. J. Jannings, III, (Fairfield); Richard Schultz (Park Ridge); V. P. Siegel (East St. Louis); and Philip Thomsen (Dolton). The committee will operate under the Hospital Licensing Board of the state.

MULTIPHASIC HEALTH SCREENING

The Board has accepted a report of its Council on Environmental and Community Health on automated multiphasic screening as an adjunct to physical examinations. The Board emphasized that it should never replace the personal element in examining a patient.

ENDORSE AMA POSITION ON V.D. CONTROL

The Board endorsed an AMA resolution calling for intensified efforts to reverse the increase in venereal disease and bring it under control by education of physicians and public, more stringent state laws, and support for national and state organizations concerned with the control of venereal disease.

PHARMACISTS EXPLAIN POSITION ON SUBSTITUTION LAWS

Representatives of the Illinois Pharmaceutical Association appeared before the Board to explain why they favor repeal of Illinois' two anti-substitution acts. They said it is not possible for a pharmacy to stock all brands of every drug and that an escape hatch is needed when the pharmacist is not able to contact the prescribing physician to get permission to substitute brands. ISMS policy developed by the House of Delegates, opposes substitution of drugs by pharmacists. The Board took no action.

EMERGENCY HEALTH CARE BY CONTRACT

The Board has approved guidelines for emergency health care by contract, developed by the ISMS Council on Social and Medical Services. The guidelines will be distributed to county medical societies and hospital medical staffs.

LEADERSHIP CONFERENCE

Advantages of medical society membership will be the subject of the fall leadership conference. The benefits of AMA membership will be featured. The program will be developed under the direction of Dr. Jacob Reisch, secretary-treasurer.

CONSENT FORM FOR THE PILL

Legal Counsel was directed to prepare a consent form for use in conjunction with the dispensing of birth control pills. Action on this was initiated by a recent adverse court decision in New York.

the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine



Fig. 1



Fig 2.

This 19-year-old girl entered the hospital with a two week history of a low-grade fever, abdominal cramps and diarrhea. There was no evidence of blood in the stools. Physical examination was noncontributory. A sigmoidoscopic examination failed to reveal any evidence of lesions. What's your diagnosis? (Figs. 1 and 2)

1. Ulcerative colitis
2. Granulomatous ileocolitis
3. Carcinoma of cecum
4. Foreign body granuloma

(Answer on page 254)



surgical grand rounds

Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of December 8, 1970.

Edited by John M. Beal, M.D.

Lung tumor following mastectomy

Case Report

Dr. Charles McHugh: A 72-year-old female obtained a chest X-ray in a mobile detection unit in June 1970, and was reported to have a solitary nodule in the left upper lung field. She was examined by her family physician who obtained serial chest X-rays during the next four months. The lesion persisted and was thought to have enlarged slightly. A tuberculin skin test in October, 1970, was positive. During the fourth month period she remained asymptomatic, and did not have specific complaints when admitted to Chicago Wesley Memorial Hospital.

Past history: In 1944, she had a left radical mastectomy for carcinoma and received radiation therapy. After this second procedure, she had an episode of severe pneumonia which required an additional six weeks of hospitalization. Periodic examination by her physician, including chest X-rays, had failed to detect evidence of recurrent breast cancer. At the time of admission, examination of the patient revealed bilateral mastectomy scars, the lungs were normal, cervical or axillary adenopathy was absent, and the liver was not enlarged to palpation. Abdominal examination was unremarkable.

Blood count, urinalysis and tests of liver function were within normal limits. The only significant findings were limited to the chest X-rays.

Dr. Abraham Cannon: We have chest films made in July, 1967, and 1970. On August 19, 1970, we see a well-circumscribed ovid lesion in the upper part of the right lung (Fig. 1). The older films showed a small lesion in the same area, which was not detected but apparently has increased in size in the interval of three years. The pre-operative films of November, the first made at Wesley, show this lesion to be larger,

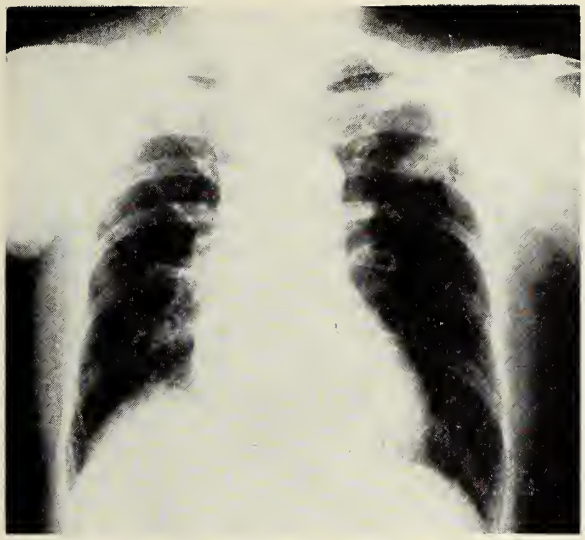


Fig. 1. Chest film taken August 19, 1970 shows solitary pulmonary lesion in left upper lung field.

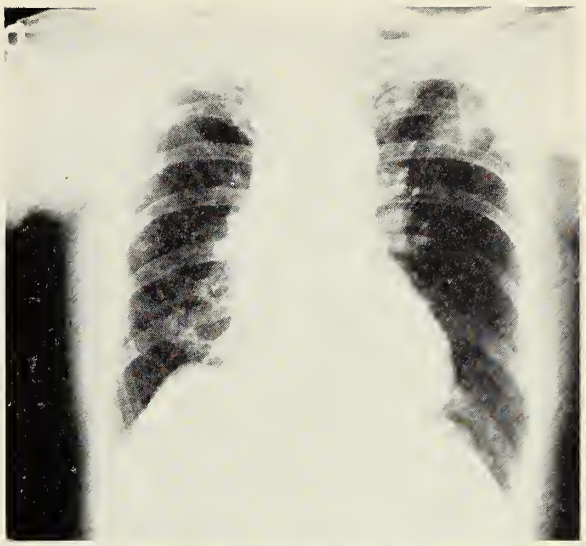


Fig. 2. Chest film, November 9, 1970, demonstrates increase in size of pulmonary lesion.

and more circular in appearance (Fig. 2). Tomographic views do not demonstrate any areas of cavitation (Fig. 3). This has the appearance of a neoplasm. It would be unusual to develop a metastasis of this size without having other metastatic lesions visible elsewhere. Granuloma could look similar to this, but usually we associate them with some calcification.

Dr. McHugh: A lung scan was also done, and showed decreased perfusion of the lateral aspect of the left upper lobe, corresponding to this solitary nodule. On November 10, the bronchoscopy was performed without abnormality being visualized. Bronchial brushings were taken, and smear and cultures for tuberculosis were obtained. Cytology was reported as class one, the smear was negative, and the culture showed normal flora.

On November 16, a left thoracotomy was performed. In the apical posterior segment, an approximately three centimeter firm, well-circumscribed mass was found. There was a large lymph node readily visible lateral to the arch of the aorta. A left upper lobe lobectomy was carried out, and the lymph node line adjacent to the pulmonary artery was examined and found to contain adenocarcinoma. Therefore, a dissection of the mediastinal lymph nodes was carried out as well.

Dr. Hector Battifora: The tumor presented grossly as a polypoid mass protruding into a secondary bronchus and infiltrating the subjacent bronchial wall and pulmonary parenchyma. Metastasis to regional lymph nodes was also evident.

Microscopically, (Fig. 4) the tumor cells are characterized by the uniformity of their size and rounded nuclei, somewhat reminiscent of plasma cell nuclei. The cells form islands or sheets and with formation of secondary glandular spaces. This histological appearance is most suggestive of a carcinoid tumor. For comparison, here is a photograph (Fig. 5) of a carcinoid of the ileum. You can see the obvious similarity between the lesions.

In order to confirm the diagnosis of carcinoid, we tried silver staining methods. As you may



Fig. 3. Tomographic technique fails to demonstrate calcification or cavitation.

Lung tumor following mastectomy

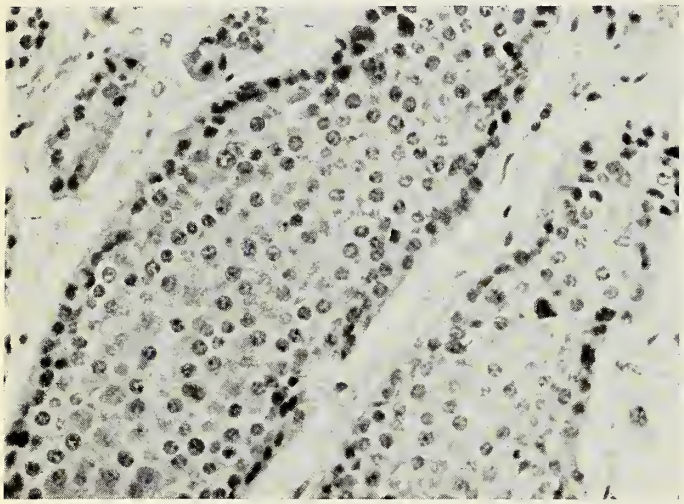


Fig. 4. Photomicrograph of representative field of the bronchial tumor. Sheets of uniform polygonal cells in the round nuclei are seen. Numerous secondary gland-like spaces are formed.

recall, these tumors are also termed argentaffinomas because of their distinctive affinity for silver ions. Unfortunately, this characteristic is missing in over 90% of carcinoids arising in bronchi. Our case was no exception.

In recent years it has become evident that electron microscopy often affords useful evidence for the diagnosis of various tumors. We therefore did electron microscopy of the bronchial tumor of this patient. The results were most gratifying since the typical dense granules of carcinoid tumors were demonstrated by this method (Fig. 6). These granules, also called neurosecretory granules, are typical of argentaffin cells and other hormone producing cells and believed to contain serotonin and other amines. They are not seen in carcinomas of the breast.

Our diagnosis, confirmed by the ultrastructural studies, is malignant carcinoid of bronchus with metastases to hilar lymph nodes.

Dr. McHugh: This patient's postoperative course was without incident. This case raises several questions: the first concerns a solitary pulmonary lesion appearing in an asymptomatic patient; secondly, how is the diagnosis and management established in a patient with a previous history of carcinoma of the breast?

Solitary pulmonary nodules as a diagnostic problem were considered by E. W. Davis in 1966, when he analyzed approximately 1200 such lesions. A solitary nodule was defined as a discreet lesion six centimeters or less in diameter, within the pulmonary parenchyma, and surrounded by aerated lung. The shape is generally round or ovoid, and the margins well-circumscribed, with the contour generally smooth and without demonstrable calcium or cavitation. Generally, once such a lesion has been found, there are few diagnostic procedures which are helpful. The patient's previous medical history may give a clue, but also may be misleading. Skin tests, culture, and smear of sputum are helpful if positive. Cytology and bronchoscopy are usually unrewarding. Negative findings do not preclude the possibility of a malignant lesion. Roentgenographic studies are perhaps the most helpful. The smaller the lesion the more likely it is to be benign; the more clearly defined the margins, the greater the chances that it is benign. Calcification is more frequently associated with benign lesions. The only definitive diagnosis is obtained by microscopic examination of the lesion. Thoracotomy should be delayed no longer than is necessary to determine the health of the patient, his ability to tolerate the procedure, and to carry out routine diagnostic procedures in the hopes that one may be able to define exactly what one is dealing with. A delay may court the possibility of metastasis from a primary bronchogenic carcinoma.

In Davis' series of 1200 cases of solitary nodule, he found that primary bronchogenic neoplasms, mainly carcinoma and bronchial adenoma, accounted for approximately 30% of his total; 358 out of 1200 cases. Metastatic tumors accounted for 69 of the 1200 cases, or five percent. Benign

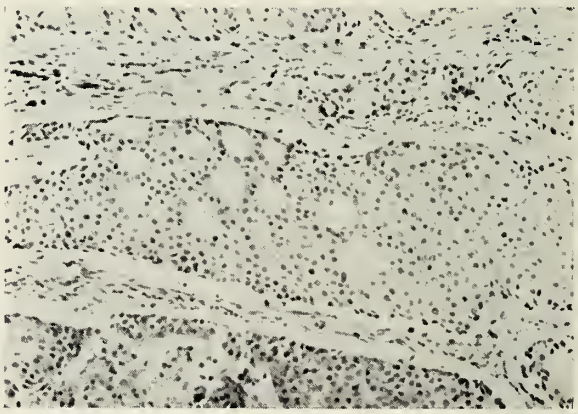


Fig. 5. Photomicrograph of a malignant ileum carcinoid for comparison with Fig. 1.

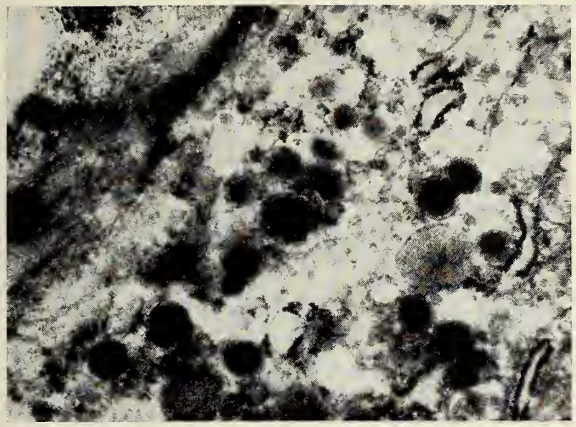


Fig. 6. Electron micrograph showing portion of the cytoplasm of a tumor cell. Characteristic electron dense, single membrane bound neurosecretory granules are present.

lesions accounted for 63% of all lesions, and granuloma was the most prevalent lesion, approximately 41.6%. Davis found a 2.5% incidence of primary pulmonary malignancy in patients who had had previous metastatic disease in another focus.

Several factors should be considered before thoracotomy is undertaken in a patient who has been treated for an earlier carcinoma. First, one should be able to establish that the original focus of carcinoma has been eliminated. Second, evidence of other metastases should be absent. Third, the lesion in question should be accessible to removal.

Dr. John Beal: Dr. Head, would you discuss the indications for operation in this patient?

Dr. Louis Head: We decided to operate on this patient because she had a lesion in her lung field which was changing in its characteristics over a period of months. The lesion was solitary. This patient is an example of the way in which we presently manage solitary pulmonary nodules. Originally, Dr. Jerome Head Sr., and Dr. Theodore Hudson recommended removing all of these lesions. Their varied experience was published in 1960. In this series, malignancy was present in 41% of coin lesions removed. For a period of time, we distinguished between primary solitary lesions and metastatic solitary lesions, recommending excisional biopsy in every case. Recently, there has been a tendency to try to diagnose the lesions more accurately and depending on the individual circumstances, to watch them with an idea of ascertaining how rapidly they are growing. Observation of a lesion for a period of six to 12 weeks will produce information as to its rate of change in size, if it is a malignancy. Should the lesion double in size within this time, no matter what is done, when it is cancer the results are going to be bad. If the size does not change rapidly, you can expect some pretty satisfactory results, even if the lesions are multiple within the lung, and regardless of whether they are primary or metastatic.

At the National Institute of Health, they have been measuring tumor doubling time, and accumulating this type of statistic. At the American Thoracic Society they presented a patient with 17 individual lesions in the lung from a primary resected sarcoma. At an operation in which simultaneous bilateral thoracotomy was performed, the 17 lesions were wedged out. The patient recovered satisfactorily and is said to be doing well. The criteria for operating was that the lesions had been observed over a period of time and had remained stable in size.

In our patient, there was a good history of a long-standing lesion in the lung field. We felt that a good surgical operation was a satisfactory solution to her problem, regardless of the histological characteristics of the nodule and irrespective of whether it was primary or metastatic. Prior to surgery we performed bronchoscopy with a flexible bronchoscope through which brushes were inserted into the lesion. A definitive diagnosis was not obtained in this manner. At the time of surgery the gland in the mediastinum was found on frozen section to be adenocarcinoma. We assumed the patient had either a second primary adenocarcinoma with positive glands in the hilum and mediastinum or that this was metastatic disease from the breast. A left upper lobectomy was done. All the glands in the mediastinum and along the trachea were resected.

The fact that this lesion is a carcinoid bronchial adenoma puts an entirely different light on the patient's prognosis. Carcinoid bronchial adenomas have a different grade of malignancy than regular cancers. They can spread into lymph glands, and into other organs of the body. However, they are of a low grade of malignancy. In many cases modified operations are done with good results. Patients have been followed for over 25 years with carcinoid lesions in the lung, treated by transbronchial resection. When these tumors do metastasize, they are often slow growing and patients are well for many years. At the present time we are caring for a patient who had a pneumonectomy six years ago for a carcinoid bronchial adenoma. At the present time she is living and active with skin and liver metastases, present for the past three years. The long history

Lung tumor following mastectomy

of this patient's experiences with carcinomas, two of the breasts and now one of the lungs, could conceivably be explained on the basis of metastases from an intestinal carcinoid tumor even though this has not been identified clinically. In spite of the fact that she has metastatic disease, I believe her outlook is excellent.

Dr. Beal: Dr. Shields, this is a subject of interest to you. What has been your experience concerning the incidence of solitary metastasis?

Dr. Thomas Shields: I have a few comments. First, in a large series of solitary nodules, the incidence of solitary metastatic lesions is well under 10%, probably in the range of one to two percent. Second, once you have a patient with a solitary lung lesion who has had a previous tumor elsewhere, he must immediately be considered in a different light than the entire group of patients that have asymptomatic, solitary pulmonary lesions. We all know that if you see enough of these patients, some will of course, have benign disease, some will have a primary lung tumor, but in the vast majority, the solitary lesion will represent a metastasis from the original site.

Cahan, of New York City, made some cogent suggestions in 1964, as to how one might approach the evaluation of these patients, and I think it is germane to mention them again. First, if the patient had a previous squamous cell carcinoma elsewhere in the body, the greatest likelihood is that the new solitary lesion of the lung represented a new primary carcinoma of the lung. Second, if the previous primary had been an adenocarcinoma elsewhere in the body, the chances are that the lung lesion is a new carcinoma of the lung in 50% of the patients with it, and in the other 50% of patients, represents a metastasis from the original primary. Third, if the patient had a sarcoma or a melanoma, with practically no exceptions, (though Dr. Stack and I do have a unique one) the second lesion in the lung almost always represents a metastasis.

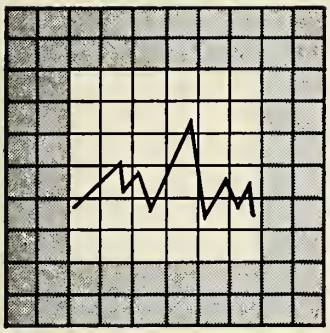
From a practical standpoint, such patients may be managed in the following ways. If the patient had a squamous cell carcinoma previously and it is controlled, and a reasonable search has been made to determine whether or not the original primary is controlled, then the lung lesion should be evaluated as if it were a new primary, and approached as such. If the previous lesion was an adenocarcinoma, one should make a diligent, thorough search for metastasis in the usual sites for the original lesion—the liver, or in the pelvis, or some other spot—depending on where the original site was. If other metastases can be ruled out, and the tumor is locally controlled, then one must treat the lung lesion on its own merit, realizing that half the time this, indeed, is a new primary.

If the original lesion was a sarcoma, however, I think a period of watchful waiting is reasonably justified, and one should wait at least six weeks, and in some tumors, depending on the degree of its malignancy, perhaps even three months. In this period of time secondary lesions usually will develop within the lung and will negate an operative approach, except in special certain circumstances, particularly in children, where a combined surgical approach and chemotherapy and/or roentgen therapy may be of benefit. At the end of the waiting period, if no other lung lesions are discernible other than the original one, the lung should be further evaluated by laminography and if no other lesions found, a surgical approach then is indicated.

In regard to diagnostic evaluation of solitary lesion, I personally believe that in the majority of patients with peripheral lesions beyond the hilum, with no roentgenographic evidence of hilar or mediastinal involvement, bronchoscopy is not required nor do they require bronchial brushing. Of course there are exceptions to this. These studies may be done in the patient who is not a candidate for operation, and who is a candidate—if you have a positive diagnosis—for roentgen therapy as well as those patients who either refuse an operative approach, or because of medical contraindications are not operative candidates.

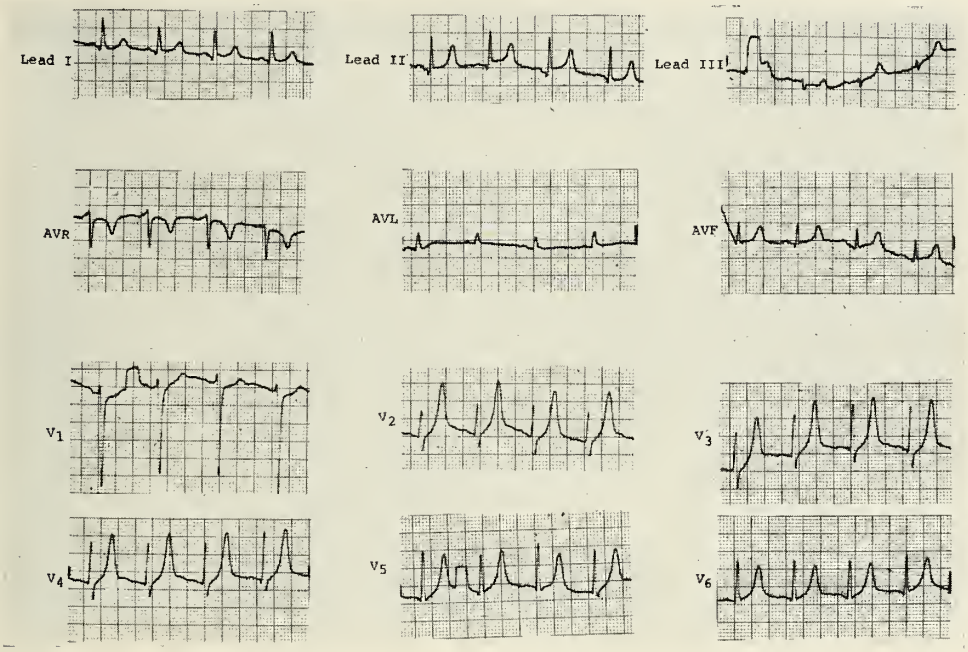
The last thing I would like to mention is that in patients who have solitary metastasis resected from the lung, 15% of these had multiple lesions in the area, although, in spite of the multiplicity of the lesions, it appeared as solitary on the overtime roentgenogram. In these patients as well as those with truly solitary metastasis and no nodes involved, the five-year survival is approximately 35%, which is just the same, or actually a little better than for primary carcinoma of the lung. ◄

(References on page 254)



ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D.
and Patrick Scanlon, M.D./Section of Cardiology,
Department of Medicine
Loyola University Stritch School of Medicine



A 47-year-old woman was admitted with a one-week history of nausea, vomiting and scanty urine. She appeared to be dehydrated, had a fever of 39°C. and bilateral costovertebral angle tenderness. The treatment consisted of intravenous fluids, KCl and antibiotics. An electrocardiogram taken two days later is reproduced.

Question (One or more of the following statements may be correct.)

The electrocardiogram showed:

A. Hypokalemia
B. Hypercalcemia
C. Hyperkalemia
D. Inferior wall myocardial ischemia.
E. Normal variant

(Answer on page 254)

Cooperative gastro-camera study with intravenous INNOVAR*

By Paul M. Egel, M.D. and Herbert R. Gaines, M.D./Chicago

THE INTRODUCTION OF A TUBE AND CAMERA through the oral cavity to study the stomach is, at best, a disturbing procedure for the patient. Even endoscopists, who know well the advantage of the examination, are often dismayed over the general patient discomfort, hypersecretion, and accentuation of the vomiting reflex caused by the tube and camera.[1] These problems complicate anesthesia since choice of anesthetic procedure can increase or decrease their severity.

Originally, we did gastric-camera studies with the Olympus GTFA using the following procedure. Premedication given forty-five to sixty minutes before gastroscopy was administered intramuscularly and consisted of 50 mg. meperidine hydrochloride, .4 mg. atropine sulfate and 50 mg. promethazine hydrochloride. In the endoscopy room, a 0.5% solution of tetracaine hydrochloride was applied topically to the oro-, posterior and hypopharynx and 1 to 2 cc. of diazepam was injected directly from a syringe into the vein very slowly. To insure patient comfort, the diazepam injection was repeated during the gastroscopic procedure. When these repeat injections were necessary, the gastroscopy had to be interrupted for five to 10 minutes. These interruptions could be avoided with a drug that could be administered along with an intravenous drip solution, but diazepam cannot be administered in this manner.

We have used Innovar* for general surgery at our institution and observed that it provided the patient with a good sedation and analgesia and the necessary tranquilization. It appeared to control those reflexes responsible for hypersecretion and vomiting which often complicate gastroscopy. Since diazepam did not appear to prevent or retard these complications, Innovar was studied to determine its effectiveness as a premedication and anesthetic agent for gastroscopic examination.

INNOVAR® Injection—Product of McNeil Laboratories, Inc., Fort Washington, Pa.

Method for Study

Since the study began in May 1969, 135 patients requiring gastroscopy have undergone the procedure described below. The patients ranged in age from 31 to 83 years, and there was an

almost equal number of men and women in the study group. Several of the patients were poor-risk patients: three had histories of coronary thrombosis, one had a complete bundle branch block, and five had arteriosclerotic heart disease. Because of its cardiovascular stability, Innovar has been recommended for use in poor-risk patients as an adjunct to anesthesia.[2]

The following technique was used to premedicate and to produce and maintain anesthesia. Forty-five to 60 minutes before gastroscopy, Innovar 2 cc. and atropine sulfate .4 mg. were administered intramuscularly. When the patient was brought into the gastroscopy room, 5 to 10 cc. of a 0.5% solution of tetracaine hydrochloride was topically applied to the oro-, posterior, and hypopharynx. An intravenous infusion was then started. The GTFA was introduced when the endoscopist was satisfied the topical anesthetic had taken effect. The patient might be supine or sitting, with the head flexed forward and chin resting on sternum. (We prefer the former position.) As the examination proceeded, Innovar was given through the infusion tubing in increments of 0.5 to 1 cc. as necessary to assure patient comfort and avert restlessness. (There has never been a need for more than 4 cc. per patient.) Innovar can be administered without interrupting the gastroscopy examination.

Observations with the Use of Innovar

Introduction of the gastroscope did not cause nausea, retching, or vomiting in any patient, and oral secretion was markedly less than with our previous technique. Oral suctioning, during manipulation of the gastroscope, was necessary for only two of the 135 patients. Patients usually have discomfort when the gastroscope is completely turned to view the gastro-esophageal junction and the cardiofundic portion of the stomach. This was of little consequence because of the analgesia and tranquilization afforded by the Innovar intravenous infusion. Since almost no gagging, retching, or oral hypersecretion occurred, easier and more thorough examination was possible.

Respiratory depression or arrest, chest rigidity, hypotension or bradycardia have not been encountered in our series to date. We did find a slight rise in blood pressure (10-15 mm. Hg.) in three patients and a pulse rate increase to 100-130 beats per minute in 10 patients with our new technique. There were no ensuing complications in these cases.

Although sedated and quiet, the patients in the series were able to help in the examination by responding to questions as instructed before the examination, i.e. nodding head or raising hand.

Only 5-10 cc. of topical anesthesia was necessary before introducing the instrument, compared with 10-20 cc. required with the previous procedure.

Case Study

The following case study illustrates the differences we found between our earlier technique and our technique using Innovar.

A gastroscopic study was performed on a white male, 44-years-old, who had a history of cirrhosis of the liver and gastric hypersecretions. Tetracaine hydrochloride, 0.5% was administered topically to the pharynx, and diazepam, 4 mg., I.V. was given slowly. The GTFA gastroscope and camera were introduced with no difficulty. Maneuvering of the tube in this patient made him quite uncomfortable and we were unable to visualize the pylorus and gastro-esophageal junction satisfactorily. The patient did not tolerate the procedure well. The aspirated secretion from the oral cavity totaled 250 cc. plus a spill on the pillow supporting his head. The viscid fluid is probably a combination of oral and gastric secretion and is often seen in patients undergoing gastroscopy.

When the patient was re-examined four months later, we used the Innovar technique and had no problem introducing the gastroscope



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HERBERT R. GAINES, M.D., (right) is chief of anesthesia at Bethany Methodist Hospital in Chicago. Dr. Gaines received his M.D. degree from Chicago Medical School.



Cooperative gastro-camera study

and camera. Examination of the stomach, esophagogastric junction, cardiac and fundic portions was easily accomplished. No oral cavity suction was required.

The gastroscope was well tolerated and no post-procedure sequelae occurred.

Conclusion

A. Blood Pressure, Pulse and respiration was monitored by an Anesthesiologist during the entire procedure.

B. Probanthine—4-6 mgm. was also given during 60% of the procedures with no untoward effect even with repeated Innovar administration intravenously.

C. Little or no resistance to the introduction of the gastroscope.

D. Minimal to no suction of oral secretion was necessary.

E. Patient resistance to lengthy procedure and observation was not present.

F. Patient acceptance of procedure facilitates teaching.

G. Blood pressure changes were not significant.

H. Pulse rate increased, but no cardiac irregularities occurred.

I. No patient rejection of repetitive tests of gastroscopy. ◄

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Thirty clinics for crippled children in October

Thirty clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The Division will hold 22 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be six special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

October 5 Quincy—St. Mary's Hospital
October 5 East St. Louis—Christian Welfare Hospital
October 6 Rock Island Cerebral Palsy—3808 Eighth Avenue
October 6 Metropolis—Massac Memorial Hospital
October 6 Hinsdale—Hinsdale Sanitarium
October 7 Sterling—Community General Hospital
October 7 Flora—Clay County Hospital
October 7 Cairo—Public Health Department
October 7 Lake County Cardiac—Victory Memorial Hospital
October 8 Chicago Heights Cardiac—St. James Hospital
October 11 Peoria Cardiac—St. Francis Children's Hospital
October 12 East St. Louis—Christian Welfare Hospital
October 12 Peoria—St. Francis Children's Hospital
October 12 Carrollton—Boyd Memorial Hospital
October 13 Champaign-Urbana—McKinley Hospital
October 14 Springfield—St. John's Hospital
October 14 Rockford—St. Anthony Hospital
October 15 Chicago Heights Cardiac—St. James Hospital
October 19 Rock Island Area General—Moline Public Hospital
October 20 Chicago Heights General—St. James Hospital
October 21 Bloomington—Mennonite Hospital
October 21 Elmhurst Cardiac—Memorial Hospital of DuPage County
October 22 Chicago Heights Cardiac—St. James Hospital
October 22 Evanston—St. Francis Hospital
October 26 Danville—Lake View Hospital
October 26 Peoria—St. Francis Children's Hospital
October 27 Springfield Pediatric Neurological—Diocesan Center
October 27 Mt. Vernon—Good Samaritan Hospital
October 27 Aurora—Copley Memorial Hospital
October 27 Centralia—St. Mary's Hospital

Adolescent nutrition

By James L. Breeling/Director, Section on Food Science/American Medical Association

As a child enters adolescence, one of his breaks away from parental authority is often in the choice of food. He begins to exercise a greater degree of freedom over what he eats. After the youngster passes puberty, we are dealing with an individual who is striving to express his unique individuality—an apartness from home and family. Paradoxically, he may seek to achieve this by huddling within the herd of his adolescent peers.

If we don't fully comprehend this fact of pre-adult life, there are those adults who do, and use this knowledge to immense profit.

In a lesson on nutrition education in an article in the June 1970, issue of *Marketing/Communications,* a publication of the advertising industry, the author said of soft drinks:

"Soft drink marketers are making more of the fact that half of all soft drinks are consumed by those under 30.

"Shasta, a growing brand which markets a broad line of flavors, takes the unusual approach of targeting advertising to an audience from two to 11-years-old. The principal reason they target so low is in response to competition. There's an expenditure of upwards of $300 million by soft-drink competitors every year against teen-agers and young adults. So Shasta goes after a market they feel is unexploited."

You may be sure that no one is spending a tenth of the $300 million on nutrition education of adolescents. Yet, these are the individuals you will see in your practices, and be expected to counsel as effectively as soft-drink manufacturers harangue.

How effective can you be?

Maybe we should begin by looking at what we know, or think we know, about nutritional status of the teen-age population.

"Caloric and Nutrient Intakes of Teen-Agers" and *"Food and Eating Practices of Teen-Agers,"* were related studies by the Division of Nutrition, School of Public Health, University of California, Berkeley, published in 1967-68. Information on caloric and nutrient intake was based upon four weekly diaries, prepared by 122 white, black and Oriental-American teen-agers, listing what

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Adolescent nutrition

was eaten, amount, method of preparation, time of day consumed, and time spent in various activities daily. In this and other similar studies, the nutrients most consistently below two-thirds of the Recommended Dietary Allowances were iron and calcium—in that order—for girls, and the same nutrients in reverse order for boys. The next most consistently low nutrients were ascorbic acid and Vitamin A. Relatively large percentages of both boys and girls had intakes of thiamine exceeding the RDA.

Protein intake was adequate on the average, although not as high as that reported by Hodges and Krehl for Iowa teen-agers in 1965. The California youths also had lower mean caloric intake than the Iowans—3,500 as against 2,800 for California boys, and 2,450 compared with slightly less than 2,000 for California girls. About 16% of the Californians' calories came from protein; protein furnished about 12% of calories for the Iowa teens.

Some differences appeared along racial lines in the California study. Caucasian boys had a higher intake of protein, calcium, Vitamin A, riboflavin, and ascorbic acid than Negro boys. Oriental boys were higher than blacks in protein, Vitamin A, niacin, and ascorbic acid. Caucasian and Oriental girls were higher than blacks in most of the same nutrients. All girls had mean iron intakes below two-thirds of the daily allowance.

Classified by socio-economic groups, boys and girls in the lower-third level had lower mean caloric intakes than other youths, and had significantly lower intakes for protein, calcium, riboflavin, and ascorbic acid. The authors felt that the mean lower intakes in black and lower-third socio-economic group teens indicated a need for enhanced nutrition education as much as improved income. Scholastic standing was not found to be important; approximately equal numbers of A and D-grade students were found in the group below two thirds of the RDA for major nutrients.

Again as in other studies, the California investigators found lower reported calorie intakes among obese than "normal" teen-agers. They were unable to determine whether this was a function of the reported enhanced fat-storage capability of the obese; whether, as Jean Mayer discovered, the obese tend to under-report food intake; or, whether the obese youngsters were motivated to eat less than usual during record-keeping periods.

Right here, I might mention a cautionary note brought to my attention by the Nutrition Clinic at Vanderbilt University. When it is important to know what a child is eating, don't take the word of the patient or his parents at face value. You will frequently be told what it is believed you want to hear. Thus, you must check the oral nutrition history against your personal observations, intuitions, and knowledge of the family circumstances. Where serious nutritional problems are known or suspected, you should consider obtaining the cooperation of a dietitian and social worker to be certain of getting as valid a picture as possible.

When the California group looked at food habits, they found that the teen is correctly characterized as a frequent eater and snacker. *It should be noted, though, that the typical teen meal pattern reported by the Californians is increasingly a meal pattern of adult America—a very small or skipped breakfast, frequently omitted lunch, heavy dinner, and many snacks.* Black boys and girls were more irregular meal eaters than white or Oriental; meal regularity tended to increase with rise in socio-economic classification; boys in the high socio-economic group were regular meal eaters, but were also the most frequent snackers; girls in this same group snacked the least often. The investigators drew the conclusion that a truly irregular pattern of eating may be more closely associated with ethnic origin than with socio-economic status.

Here are the recorded meals of several of the teens, offered by the investigators as typical of their groups:

Caucasian boy, 18, high socio-economic group: *7 a.m. breakfast*—cereal with cream and sugar, doughnut, cup of milk; *8 a.m. snack*—coffee with sugar; *lunch*—two peanut butter and jelly sandwiches, six cookies; *3 p.m. snack*—root beer; *6:45 p.m. dinner*—beef stroganoff, rice, lettuce salad; *11 p.m. snack*—rye wafer with butter, two apples.

Oriental girl, 15, middle socio-economic group: *breakfast*—bologna sandwich with mayonnaise and mustard; *lunch*—bologna sandwich with mayonnaise and mustard, potato chips, cola drink; *5 p.m. snack*—fried egg, three slices toast with butter, ½ cup milk; *6:30 p.m. dinner*—two

cups rice; *9 p.m. snack*—cola drink, piece of hard candy; *11 p.m. snack*—cola drink, ice cream.

Negro Boy, 17, middle socio-economic group: *breakfast*—none; *10:40 a.m. snack*—package hard candy; *11 a.m. snack*—fruit punch, six peanut butter and cracker sandwiches from vending machine; *1 p.m. snack*—candy bar; *2 p.m. snack*—candy bar; *5:45 p.m. dinner*—fried liver, bread dressing, ear of corn on the cob, lettuce and tomato salad with mayonnaise; *9:40 p.m. snack*—six peanut butter and cracker sandwiches from vending machine.

Negro girl, 16½, low socio-economic group (responsible for her own meal preparation): *breakfast*—none; *8 a.m. snack*—popsicle, *9:30 a.m. snack*—carrot, stick of celery; *lunch*—orange, two doughnuts with chocolate icing; *4 p.m. snack*—potato chips, corn chips, popcorn, three slices of salami; *8:40 p.m. dinner*—tuna pie, large cola drink.

These diets are offered as being representative, and to dramatize the fact that nutrition does not always come in neat packages. The Oriental girl who ate bologna sandwiches for breakfast and fried eggs for snacks did not come off badly in nutrient intake. It shouldn't necessarily be discouraged. Some other unusual but perfectly adequate breakfast items were: barbecued chicken, steak, pork chops, frankfurters.

Meats were well accepted and eaten by all the racial and socio-economic groups. Vegetables were least regularly consumed by all groups; black boys and girls in the lower socio-economic group ate less raw fruits and vegetables, more cooked vegetables than other groups. Caucasians in all socio-economic groups were the greatest consumers of dairy products.

About 20% of the boys and 25% of the girls reported taking vitamin pills with regularity. All were in the middle or upper socio-economic groups, and all but one were Caucasian or Oriental. The investigators noted that common vitamin supplements do not contain iron or calcium, the two most neglected nutrients.

Overall, the youngsters who appeared most in need of nutrition counseling in view of inadequate food habits were Negro girls and obese girls of all races and socio-economic groups.

In a third study by the Berkeley group, determination of body composition of 1,000 high school teen-agers revealed that 10-15 per cent of the population was obese; a similar percentage of obesity among teen-agers was found by Jean Mayer and associates in a paper published in 1967. A higher prevalence of obesity occurred in the lowest socio-economic group, and proportionately more Negroes than whites or Orientals were obese.

The Berkeley investigators found, as Eppright did in a 1955 study of Iowa teen-agers, that obese girls tended to have a lower intake of protein, vitamins and minerals than girls of normal weight. To what does one attribute the phenomenon?

Obese teen-agers may have bad food habits, but if they do, it is apparently not because they are ignorant of good food habits. Mayer and colleagues reported that knowledge of nutrition among teen-agers was highest among dieters and the obese. Many obese teens, especially girls, were reported as chronic dieters who had poor to moderately good success in losing weight—but they frequently followed a lose-gain-lose-gain pattern.

This would indicate that obese teens are often motivated to gain considerable nutrition knowledge but may have trouble putting it to use—needing further guidance and psychological support. Chronic dieting "splurges" may leave them in something of a nutrient deficit. The physician should therefore be aware that an obese teen-ager may need nutritional support in addition to counseling and consideration of metabolic disorders underlying the obesity.

The adolescent girl is the teen-ager who is likely to regard obesity with the greatest degree of horror—particularly now, when the ideal body-image of the teen-age girl is that of a rangy ectomorph. Efforts by non-obese girls to achieve the ectomorphic ideal probably leads them into very strange food choices, and perhaps into malnutrition.

This "felt need" of the adolescent girl for dieting may be one reason why she has the poorest diet of any member of her family—regardless of socio-economic strata. Even in poor families, poverty and nutritional ignorance may be less important than dieting as contributors to poor nutrition of adolescent girls.

Poor Diet and Pregnancy

The adolescent girl in poor nutritional status is not ready for pregnancy. It is now fairly well accepted that poor nutritional status may play a role in the poor obstetric performance of a high percentage of teen-age girls, along with inadequate development of the endocrine system, high incidence of out-of-wedlock status, and inadequate prenatal care. The stresses of pregnancy are added to the nutritional needs of maturation, and are often superimposed upon a poor nutritional status.

Adolescent nutrition

The Chicago Board of Health looked at dietary habits of teen-agers receiving maternity and infant care under a special project between 1965 and 1967. The girls were classified as high-risk patients by virtue of being 15 years or younger; 92.9% were black. Information on dietary habits was compiled from 996 completed questionnaires filled out by the girls in consultation with a nutritionist. Results were given in an unpublished report.

Food habits were rated as good for 30% of the group, fair for 26.4%, and poor for 43.6%. Twenty per cent of the girls ate two meals or less per day. Ten per cent were eating corn starch upon the advice of family members or friends, who promoted the habit as being helpful to a successful pregnancy.

The most neglected food groups were milk and milk products (59% of the girls had low intake); leafy, green and yellow vegetables (49% with low intake); and, other fruits and vegetables including potatoes (91.8% with low intake). Only 23.7% were found to have low intake of animal and vegetable protein foods. One can say that, with this dietary pattern, a majority of the girls must have had inadequate intakes of calcium, Vitamin A, and ascorbic acid. Iron intake was probably low, also a matter of special concern during pregnancy.

Nutrition counseling was among prenatal services offered to the girls in the Board of Health project. The investigators felt the services did improve the outcome of pregnancy. Comparing results in project girls and girls of similar age and general background under private care, clinic care, or no care, they reported: a prematurity rate of 13.5 in project patients, 19.2 in non-project; hebdomadal death rates 125% higher and neonatal death rates 136% higher in non-project girls.

The Chicago Board of Health project grappled with the nutritional dislocations of a fairly homogeneous group of girls—black, poor, and pregnant. It began to utilize what we like to call, in our love of catch-phrases, an inter-disciplinary approach to nutrition education, eliciting cooperation from physician, nutritionist, nurse, and social worker in a clinic setting. If an approach works, it deserves another try, perhaps with other teen-agers who can be reached in some institutional context.

Nutrition Education Ineffective

A nutrition education approach that demonstrably works is really an oddity, particularly where adolescents are concerned. Nutrition educators are beginning to realize that nutrition education circa 1900, dealing with the four basic food groups, is dull and obsolete in terms of today's 10,000 items in the supermarket, and general movement toward a snacking, multi-mini meal existence. But nutrition education circa 1900 is about what we are stuck with at the moment. Nutrition education is a field waiting for the "Big Idea."

We can recognize the truth of a statement by Dr. Howard Jacobson, Associate Professor of Obstetrics, University of California Medical Center, San Francisco: "By the time we get the adolescent in our pre-natal clinic, how much can we teach them about nutrition? A better base needs to be built in the school and the home."

Can we expect the job to be done at home when the meal patterns of American families are dissolving?

Can schools do the better nutrition education job that we need? Dr. Ruth Leverton, nutritionist of the U.S. Department of Agriculture, says nutrition educators have some solid ground to build on, if they will use their imaginations. Among these potentialities she lists: (1) adolescents get hungry; (2) they like to eat; (3) they want energy, vigor, and the means to compete effectively; and, (4) many still have good food habits, or memories of good food habits, established in childhood.

She asks would-be nutrition educators to consider some reasons why nutrition education may fail:

(1) Too often, teen-agers have been subjected to nutrition education which says, in effect, "good nutrition means eating what you don't like because it's good for you."

(2) Most teen-agers are not experiencing the nutritional disaster that adults have warned them will result from poor food habits.

(3) Food is only one component of the busy lives of teen-agers, who have their own lives to lead plus fulfilling the expectations of parents and schools; food can receive only a fraction of their attention.

(Continued on page 258)

"Home Rule powers" may threaten physicians

As of July 1, 1971 the State of Illinois has been operating under its new constitution.

The most significant political changes made by the 1971 Constitution are found in the Local Government article (Article VII). Local municipalities—especially home rule units—have been provided powers they have never before enjoyed.

A home rule unit includes any municipality with a population of 25,000 or more, or any county with an elected chief executive officer (Cook County only). In addition, any other municipality may, by referendum, place itself in the home rule category.

As of the 1970 census, the following 58 municipalities meet the home rule requirements:

Alton (Madison)
Arlington Heights (Cook)
Aurora (Kane)
Belleville (St. Clair)
Berwyn (Cook)
Bloomington (McLean)
Calumet City (Cook)
Champaign (Champaign)
Chicago (Cook)
Chicago Heights (Cook)
Cicero (Cook)
Danville (Vermilion)
Decatur (Macon)
DeKalb (DeKalb)
Des Plaines (Cook)
Dolton (Cook)
Downers Grove (DuPage)
E. St. Louis (St. Clair)
Elgin (Kane)
Elmhurst (DuPage)
Elmwood Park (Cook)
Evanston (Cook)
Evergreen Park (Cook)
Freeport (Stephenson)
Galesburg (Knox)
Granite City (Madison)
Harvey (Cook)
Highland Park (Lake)
Joliet (Will)
Kankakee (Kankakee)
Lansing (Cook)
Maywood (Cook)
Moline (Rock Island)
Morton Grove (Cook)
Mt. Prospect (Cook)
Niles (Cook)
Normal (McLean)
Northbrook (Cook)
North Chicago (Lake)
Oak Lawn (Cook)
Oak Park (Cook)
Palatine (Cook)
Park Forest (Cook)
Park Ridge (Cook)
Pekin (Tazewell)
Peoria (Peoria)
Quincy (Adams)
Rantoul (Champaign)
Rockford (Winnebago)
Skokie (Cook)
Rock Island (Rock Island)
Springfield (Sangamon)
Urbana (Champaign)
Villa Park (DuPage)
Waukegan (Lake)
Wheaton (DuPage)
Willmette (Cook)

A great amount of power is now vested in these 58 home rule municipalities and the home rule county of Cook. They now have:

★ The power to regulate for the protection of the public health, safety, morals and welfare.
★ The power to change their forms of government by referendum.
★ The power to license (but not for revenue unless authorized by the General Assembly).
★ The power to tax (except upon income or occupation unless permitted by the General Assembly.)
★ The power to incur debt subject only to constitutional or statutory limitations.
★ The power to punish.

The General Assembly is unlikely to rescind any of these powers, since it would take at least a three-fifths vote of each House. Under the present political structure and influence possessed by the home rule units (notably Chicago), there is doubt whether a legislative proposal would receive the necessary 35 affirmative votes in the Senate and 106 votes in the House to pass any restraints.

The delegated power having the most impact upon the individual physician is the one permitting home rule units to license.

The home rule unit is prohibited by the Constitution from licensing for revenue, but in many instances government is just a case of semantics. The municipality may decide it must produce a directory of physicians for reference use. In order to do so it must have the home and office of each physician. The best way to maintain contact with physicians is to license them.

Licensing and publication of a directory takes staff, so the physicians being licensed pay a fee to maintain the administrative personnel. Any revenue not used by these personnel would be returned to the general fund.

What would happen to the physician who lives in Maywood (Cook County), has an office in Elmhurst, is affiliated with a hospital in La Grange and makes house calls in Melrose Park. He could be licensed by Illinois, Cook County, Maywood, Elmhurst, LaGrange and Melrose Park.

(Continued on page 242)

What you should know about the Illinois Controlled Substances Act . . .

The Illinois Controlled Substances Act, (ICSA), signed into law on August 16, 1971, became effective immediately. Certain provisions of the Act parallel those of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, which became effective May 1, 1971, and under which amphetamines were recently rescheduled to the more rigidly controlled Schedule II. Certain provisions of ICSA are more stringent than those in the Federal Act. One of them relates to the use of the official Illinois triplicate prescription form.

Prescribing Requirements

1. Prescribers must utilize the official Illinois triplicate form for:
 a.) Narcotic preparations previously ordered on this form including Alvodine, Cocaine, Codeine, Demerol, Dilaudid, Dolophine, Leritine, Meperidine, Morphine, Opium, Percodan, and Spasmalgin.
 b.) Preparations containing *methamphetamines* including: Desbutal, Desoxyn, Efroxine, Methedrine, Norodin and Syndrox.

2. Prescribers are required to prescribe the following amphetamine containing products *in writing*, but ordinary prescription blanks may be used: AM Plus, Amphetamine, Amvicel, Bamadex, Biphetamine, Biphetamine-T, Daprisal, Dexamyl, Dexedrine, Dextro-amphetamine, Obedrin, Obocell, Phantos, Seco Synatan, Synatan Forte. Eskatrol will be in this category after September 13, 1971.

3. Prescriptions for the drugs listed in 1 and 2 above may not be refilled by pharmacists. ICSA provides that prescribers may use ordinary prescription blanks to order Schedule II drugs in an emergency. ICSA provides that prescribers may order Schedule II drugs by telephone (or other oral order) in an emergency.

4. All other controlled substances may be prescribed by telephone or in writing and refills may be authorized for a period of six months, or for the duration of five refills. This includes narcotic preparations such as Paregoric and Empirin Compound with Codeine.

Other ICSA Provisions

While physicians will be required to register with the Department of Registration and Education in order to prescribe or dispense drugs controlled under ICSA, a practitioner who is in compliance with the Federal law with respect to registration "need only send a current copy of the Federal registration to the Department of Registration and Education." No immediate action need be taken; regulations will be forthcoming.

- Record keeping requirements are the same as those for the Federal controls.
- Acquisition of controlled substances in Schedules I and II will be made upon the official BNDD order forms.
- Physicians will be supplied (upon request and payment of $3.00) 100 official Illinois triplicate prescription order forms.
- Physicians who dispense controlled substances will be required to label the container to show his name, address, BNDD registry number, the name and address of the patient and the directions for use.

Hospitals employ 292 personnel per 100 patients in '70

The nation's community hospitals employed 292 personnel per 100 patients in 1970, according to statistics released by the American Hospital Association.

The figure represents a new high in hospital manpower. In 1969, there were 280 employees for each 100 patients. Ten years ago, community hospitals employed 226 personnel per 100 patients.

In 1970, AHA registered 5,859 community hospitals.



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

Generic Drugs

The following new drugs have been marketed:

Duplicate Single Products

PAP-KAPS Vasodilators-Peripheral ℞
Manufacturer: Sutliff & Case
Nonproprietary name: Papaverine HCl
Indications: Relief of cerebral and peripheral ischemia associated with arterial spasm and myocardial ischemia complicated by arrhythmias
Contraindications: None mentioned
Dosage: One capsule every 12 hrs.
Supplied: Sustained release capsules, 150 mg.

Combination Products

HEMA-C Hematinic/Vitamin Combination ℞
Manufacturer: Sutliff & Case
Composition:

Ferrous Fumarate	300 mg.
Ascorbic Acid	200 mg.

Indications: Hypochromic (iron deficiency) anemia
Contraindications: Hemosiderosis and hemochromatosis
Dosage: Adults: 1 capsule daily
Children: On advice of physician only
Supplied: Sustained release capsules

KELYUM Hospital Solution ℞
Manufacturer: Strasenburgh Pennwalt, Div.
Composition: Each 15 cc. provides:

Potassium ion	20.00 mEq.
Chloride ion	3.33 mEq.
From	
Potassium gluconate	3.897 gm.
Potassium chloride	0.249 gm.

Indications: Oral potassium therapy
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause
Dosage: One tbs. (15 cc.) in one fluid oz. or more of water twice daily
Supplied: Liquid, 1 pint bottles

M-M-R Biological ℞
Manufacturer: Merck Sharp & Dohme
Composition: Each dose of reconstituted vaccine contains not less than:

Measles virus vaccine, live, attenuated	1000 $TCID_{50}$*
Mumps virus vaccine, live	5000 $TCID_{50}$
Rubella virus vaccine, live	1000 $TCID_{50}$

(*Tissue culture infectious doses)
Indications: Simultaneous immunization against measles, mumps and rubella in children from one year to puberty
Contraindications: Pregnancy. Sensitivity to chicken or duck or their eggs or feathers or neomycin. Any febrile respiratory illness or infections, active untreated tuberculosis. ACTH, corticosteroid, irradiation, alkylating agent or antimetabolite therapy. Blood dyscrasias, leukemia, lymphomas or malignant neoplasms affecting the bone marrow or lymphatic systems. Gamma globulin deficiency.
Dosage: s.c., inject total volume of reconstituted vaccine into outer aspect of upper arm
Supplied: Vials lyophilized vaccine

MYOLATE Analgesic-Non-narcotic ℞
Manufacturer: Amfre-Grant
Composition:

Isobutyl-Allybarbituric Acid	50 mg.
Acetaminophen	300 mg.
Phenacetin	130 mg.
Caffeine	40 mg.

new pharmaceutical specialties

Indications: Tension headache and head pain associated with upper respiratory infections
Contraindications: Hypersensitivity to any of the components
Dosage: 1 to 2 tablets. Repeat if necessary up to 6 per day
Supplied: Tablets

TOL-C Hematinic/Vitamin Combination ℞
Manufacturer: Ascher
Composition: Ferrous fumarate 300 mg.
(Elemental iron 100 mg.)
Ascorbic Acid 500 mg.
Indications: Iron deficiency anemia
Contraindications: Peptic ulcer, regional enteritis, ulcerative colitis
Dosage: One tablet once or twice daily
Supplied: Tablets

New Dosage Forms

HALDOL Ataraxic ℞
Manufacturer: McNeil
Nonproprietary name: Haloperidol
Indications: Acute agitated psychosis
Contraindications: Severe depression, coma, CNS depression or Parkinson's disease
Dosage: i.m., 3 to 5 mg. individualized
Supplied: Ampuls—1 cc., 5 mg.

NILSTAT Fungicides-Vaginal ℞
Manufacturer: Lederle
Nonproprietary name: Nystatin
Indications: Local treatment of vaginal infections caused by **Candida (Monilia) albicans.**
Contraindications: Hypersensitivity to nystatin
Dosage: One or two vaginal tablets daily for two weeks
Supplied: Vaginal tablets, 100,000 units

Generic Drugs

Since an increasing number of pharmaceutical manufacturers, who are selling drugs on a national basis, are offering drugs under a generic name either for sale to hospitals or pharmacies, it seems advisable to list the marketing of such drugs under a special classification.

PYRAZINAMIDE Antitubercular ℞
Manufacturer: Lederle
Nonproprietary name: Pyrazinamide
Indications: Active tuberculosis after failure with primary antitubercular drugs
Contraindications: Severe hepatic damage
Dosage: Administer with at least one other antitubercular drug. 20-35 mg./kg./day in 3-4 divided doses. Do not exceed 3.0 gm. per day
Supplied: Tablets, 500 mg.

VD ranks high as communicable disease

The American Medical Association Council on Environmental and Public Health reports that gonorrhea ranks first and syphilis third among the reportable communicable diseases in the United States. For the year ending June 30, 1970, infectious syphilis rates were eight percent higher nationally than a year earlier, with annual increases spread over 33 states and an estimated incidence between 70-80,000 reported cases: there are 250,000 cases of all forms of syphilis estimated to be diagnosed and treated each year.

At the same time, gonorrhea morbidity exceeded 573,000 reported cases. Gonorrhea is pandemic in the United States, with an estimated two million cases.

Physicians in private practice treat approximately 80% of the syphilis and gonorrhea that comes to diagnosis but report to public health departments only one out of every eight cases of syphilis and one out of every nine cases of gonorrhea they treat. Physicians should assist public health departments by reporting the VD cases they treat. Medical societies are urged to cooperate and give broad support to public health authorities. Much effort must still be made by health departments and medical societies to foster mutual trust so that public and private medicine can work effectively for the control of both syphilis and gonorrhea.

The American Medical Association is making VD a national theme for Community Health Week-1971, with suggested dates of October 17-23. Informational and promotional material will be available for medical societies.



editorials

Psychoactive drugs

Annually, pharmacies fill more than 200 million prescriptions for psychoactive drugs. Most of these compounds are prescribed to alleviate feelings of anxiety, frustration, agitation and depression. Their popularity has not waned despite our knowledge that psychoactive drugs do not eradicate the ordinary problems of life that people face every day. Actually "taking something" may be a crutch but is not the solution to man's many discomforts.

Why does the medical profession resort to these drugs? Perhaps, it is the easy way to manage patients with emotional problems. The alternative is to use restraint or refer the sufferer to other resources in the community where he can find relief. Too little is known about the potential damage done to the nervous system and personality of the user. After all, pharmacologists do not know the immediate and long range personal and social consequences of these drugs.

In the past, physicians were better listeners, and more compassionate. Efforts must be made to create a society in which man is faced with as few tribulations as possible. Some may not consider this to be a strictly medical approach, but in the long run it may prove to be in our best interests. Nothing can be gained if human misery is the price extracted for progress in any discipline.

Drugs provide only temporary effects; they do not help a person learn to live with himself and others. And this cannot be done with machines. Nor can our young people learn how to be humane if it is done in classes and lecture halls stripped of human inputs.

T.R. Van Dellen, M.D.
Editor

'Let George say it'

The Food and Drug Administration is regularizing the pharmacopoeia. Inexorably, the noose of federal restriction is tightening about the neck of every physician. So insidiously has this been carried out that practically no objection has been raised. Even a trustee of the AMA has agreed that it is right to drop drug combinations that are "probably not effective."

While doctors have given most of their attention to government medical insurance plans, this program has been moving forward quietly. Committees of experts have been set up to evaluate drugs. Who names the experts is not explained, nor how their fields of expertise are applied, but it appears that they are well-regarded physicians who seriously consider their tasks.

The tasks are even less clear. Apparently, currently marketed pharmaceuticals are evaluated as— effective, probably effective, possibly effective, probably not effective, and not effective. It is a subjective evaluation that places an item in one category rather than another. It is easy to see that one man would weigh one end of such a scale heavier than would another.

The next step is more interesting. Evaluations of medical experts are turned over to bureaucrats. Suddenly there is a recommendation that "X" medicine, being doubtfully effective should be "not approved."

The sad part about this is that "not approved" has the same effect as interdiction. Drugs on this list will be forever beyond the doctor's reach.

Today we see old familiar combination medicines outlawed. The succession follows inevitably. As the world of medicine accepts one inroad, the next is driven a little deeper. The

antibiotics will be winnowed away. Perhaps we will be left with one penicillin, one tetracycline. Some great allergist's favorite antihistamine will survive alone. One steroid will be enough. The TV battles of the pain killers will be no more when the directive wipes out all but aspirin.

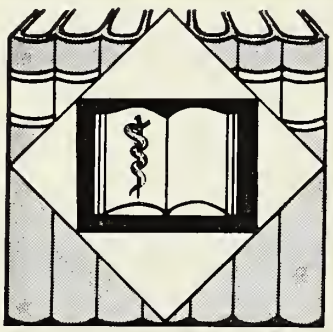
Soon even the names will be dropped. Since all allowable drugs will be part of the official formulary, only a number will be needed on a prescription. It will do no good to write for anything else. It would be illegal and in any event unavailable.

The ghost of Dr. Humphrey, the homeopathic patent medicine king, is chuckling over us. Soon all the triumphant therapeutic achievements of American medicine will be cut down to numbered items in a federal registry.

Because doctors do not like to make a fuss and because some of these drugs really may not be very good, American medicine lies back and suffers a mortal ravishing. If this run scores, medicine and American civilization will have lost a major baseball game.

George A. Rowland, M.D.
Millville, Pennsylvania

(Reprinted from July, 1971 issue of Pennsylvania Medicine)



the doctors library

Congenital and Pediatric Glaucomas. By Robert N. Shaffer and Daniel I. Weiss. C. V. Mosby Company, St. Louis, 1970. (221 pages, 3 color plates, price $20.50)

As the authors point out, glaucoma can be a silent thief of vision in children as well as in adults. However, it is much less common in children. Primary congenital glaucoma is sufficiently rare that no more than one new case can be expected to be seen in five years in a standard opthalmologic practice. The tragedy, measured in years of vision lost can, however, be much greater. Early diagnosis and treatment is critical. The authors have therefore designed their book, one of the few available devoted solely to this subject, to alert the pediatrician and family physician to the possibility of primary glaucoma in children and to familiarize them with many conditions in which it is often an associated finding. In addition, it provides an excellent one stop reference to pediatric glaucomas for the practicing opthalmologist and resident-in-training.

The senior author is co-author of one of the major current books on glaucoma and this book borrows freely for background material and classification from that previous work. This book focuses on a limited area with greater detail and is well up-to-date.

The book is broken down into segments, the first of which, a classification of glaucomas and discussion of some rudimentary genetics, seems unnecessarily dry or lengthy. The section on diagnosis will be of most help to the practicing ophthalmologist although the well documented and excellent emphasis on optic nerve head changes is of importance to all physicians. The subsequent chapters describe not only the symptoms of primary congenital glaucoma but the many related disorders, syndromes, and diseases in which glaucoma may also be found. These divisions will be most helpful to pediatricians and others to whom the burden of discovering these cases early, usually falls.

The final segment on therapy will be of use primarily to the practicing ophthalmologist—the surgical discussion is well detailed and very useful without pretentions to being an atlas. The medical therapy section is pharmacologically complete but disappointing with no mention of how and when the authors actually utilize such therapy in these conditions and with what success.

The book is beautifully illustrated and printed

in an attractive and flawless format, which is almost taken for granted for the publishers. It is a book which will be appreciated by any ophthalmologist who treats these children, and by pediatricians and family physicians who wish a handy reference for the occasional case which will raise this diagnostic possibility.

Paul E. Romano, M.D.

Emergency Room Journal Articles. Edited by Gelperin, E. A. and Gelperin, O. Medical Examination Publishing Company, Inc., Flushing, N.Y., 1970.

Recognizing the growing importance of the emergency room, both as a provider of medical service and as the hospital's "show case," the authors have compiled this group of recent articles dealing with the hospital emergency room. The book is divided into three main sections.

The first group of articles discusses the law and its relation to the emergency room. Unfortunately, the laws differ widely from state to state, making it difficult to precisely define a true emergency, the types of treatment centers or the responsibilities of the hospital and the individuals working in the emergency department.

The second section deals with the organization of the emergency department. Along with articles on staffing and education, this section includes an excellent discussion of triage methods and lifesaving procedures.

The last section pertains to the management of the specific medical and surgical problems most commonly encountered in the emergency room. Discussions of the comatose patient, acute low back pain, multiple injuries, and head injuries are particularly valuable.

This book was not written for, nor will it be of much value to the expert in trauma. On the other hand, it does provide much useful information for the administrators, nurses, and young house staff officers who work in the hospital emergency room.

Stuart M. Poticha, M.D.

Obituaries

Mrs. Frances C. Zimmer, "First Lady" of ISMS, died August 14, in the home of a cousin in South Pasadena, California, while waiting to move into her new home there.

After retiring on March 30, of this year after 35 years of service to ISMS, Frances moved to California where she purchased a home at Leisure World in Laguna Hills, California.

She joined the Society in 1935, when the headquarters office was located in Monmouth, Ill., and staffed the office with Dr. Harold M. Camp. When the office was relocated to Chicago in 1960, Frances moved with it and served as executive assistant until her retirement.

She was preceded in death by her parents, Mr. and Mrs. Anthony Carpenter, and her only sister, Mrs. Alice Ritzinger McKitterick. She is survived by a niece, Mrs. Don Rosche of Northbrook, Ill., a nephew, Tom McKitterick of Madison, Wis., and a cousin, Dr. Edwin Carpenter, who she was visiting at the time of her death.

While living in Monmouth, Frances was active in the National-Polio Foundation, the Monmouth Country Club and the A.A.U.W. In Chicago, she held membership in the American Association of Medical Society Executives, P.E.O. and the Chicago Camera Club. In addition, she did volunteer work for Wesley Memorial Hospital for several years.

At the time of her death, she was working on her Congressional certification in Braille.

Graveside services were conducted on August 23, in Burlington, Ia., with Dr. and Mrs. Edward A. Pisczek representing ISMS.

***Norman S. Beebe,** Colfax, died July 8, at the age of 65.

***Homer L. Parker,** Pontiac, died July 11, at the age of 75. Dr. Parker was on the St. James' Hospital medical staff.

***Thomas E. Speer,** Merrillville, Indiana, died July 29, at the age of 42. He worked for the Chicago Northwestern Railroad.

****George A. Tankersley,** Taylorville, died July 29, at the age of 84.

Joseph P. Gard, Chicago, died July 26.

***Joseph L. Patka,** Chicago, died July 29.

***E. S. Frazier,** Effingham, died June 20, at the age of 67. Dr. Frazier was past president of the Effingham County Medical Society where he practiced for more than 33 years.

***Michael Leventhal,** Chicago, died July 8, at the age of 69. He had been on the staff of Michael Reese Hospital since 1924.

Walter Oliver, Chicago, died July 14.

Harry M. Slosberg, Chicago, died July 14.

Ralph A. S. Logan, Villa Park, died July 22.

****Peter J. Werner,** Chicago, aged 74, died June 17. He practiced for more than 50 years.

****Fred J. James,** Paris, died July 6, at the age of 83. Dr. James, a semi-retired physician was in his sixtieth year of practice.

**ISMS member*

***ISMS member and Fifty-Year-Club member*



practice management

Billing under the new fee-splitting legislation

By Robert P. Revenaugh/Professional Business Management, Inc.

Under an amendment to the Illinois Medical Practice Act recently signed by Governor Ogilvie fee-splitting is illegal. Fee splitting is defined as paying or receiving rebates or commissions from any person for professional services not rendered. Where, on the other hand, services are rendered by both doctors, a division of fees is proper as long as the patient has full knowledge of both doctors' fees and provided the division is in proportion to the services performed and the responsibility assumed by each doctor.

One of the penalties for violation of this portion of the Medical Practice Act may be the suspension or revocation of the physician's license to practice in the State.

Another penalty which results from the law concerns the deductibility of fees paid to a participating doctor. The IRS traditionally has followed the premise that deductions for payments to a participating doctor in Illinois will be allowed so long as they do not violate public policy. While fee splitting in the past has been unethical in all medical societies, it now becomes illegal. Armed with the new law, the IRS presumably will challenge the deductibility of amounts paid to a participating physician. Unless the full requirements of the new law are met, failure to meet the requirements of this new law could lead to disastrous income tax results.

For example, suppose that Dr. G. Practice assists Dr. Surgeon in an operation and does follow-up care on Practice's patient, Mr. Sick. Dr. Practice then bills the total fee to Mr. Sick but forgets to itemize his fee and Dr. Surgeon's fee. After a few months the total fee—$400—has been paid to Dr. Practice. Dr. Practice then pays Dr. Surgeon $300 and deducts the $300 payment on his tax return at year end. The IRS would be expected to disallow this deduction because Dr. Practice failed to comply with the State law requiring disclosure to the patient of respective fees. Dr. Practice has in effect earned nothing for his efforts—in fact, he has lost money. Presuming he is in the 50% tax bracket, he paid to IRS 50% of the $400 practice receipt, or $200, which leaves him $200 after taxes. He paid Dr. Surgeon $300 which ended up non-deductible. Therefore Dr. Practice ends up with a $100 loss after taxes for his effort. Simply stated, if audited, a doctor billing the total fee will yield very little, if anything, for his efforts unless he complies with this law.

Nothing in the law prohibits two doctors from working together on a case. Nothing prohibits them from billing separately for services which they performed. Nothing prohibits them from rendering a combined bill for services rendered to the patient as long as the requirement of a full disclosure to the patient is met. Nothing prohibits them from rendering a total bill to an insurance company without disclosing the respective fee of each doctor. Nothing in the law dictates the allocation of the total fee between the participating doctors provided the division is in proportion to the services performed and the responsibility assumed by each.

It is not our intent to discuss either the pros

or cons of this law but rather to review its implications, particularly in regard to the billing of fees. There are several methods of billing.

Billing Methods

The first, and probably the simplest, at least in theory, would be for each doctor to bill the patient and the insurance company separately for the services rendered by him. Unfortunately at least in some parts of this state, this can cause problems between the patient and his insurance company. It may also cause friction between the two doctors.

Insurance companies don't consistently treat claims for assisting and for attending physicians services. Around the Chicago area as an example: Medicare accepts separate billing, pays for surgery, surgical assists, and attending physician's services. They may, however, ascribe fees for hospital visitations just before and just after surgery as being part of the surgery fee. Blue Shield pays for surgery, they pay for attending services but except under a few policies they will not pay for surgical assists or consultations. Other private insurance companies in approximately 60%—70% of the claims will not honor any bills for attending or assisting. With separate billing the patient may end up with a lesser share of his total billing being paid by his insurance. With separate billing the surgeon may have his bill paid immediately and fully by insurance whereas the doctor who has referred, assisted, and attended may end up hopefully collecting from the patient.

The second method of billing is for either one of the doctors to send a combined bill, listing the amount due each physician. He would then fill out and submit the insurance forms for the total fee. When payment is received by the billing doctor he would remit the agreed portion of the fee to the participating physician. This method has the disadvantage that one doctor is solely responsible for the collection of the fee and for the remittance to the participating doctor. However, if his collection policy is adequate and both doctors agree on the method of billing and of payment to the participating doctor, this method can be quite workable. Probably, the specialist should be the billing doctor because the patient may obtain a larger indemnification from the insurance comany.

Whichever type of billing is utilized is a matter to be decided by the doctors involved. The advantages and disadvantages of both should be weighed. Either method, however, does comply with the requirements of disclosure.

My experience in helping doctors on the business side of their practices has frequently led me before the IRS on their behalf. I am convinced that when the impact of this legislation filters down to the IRS agents, payments to other doctors appearing on your tax return will be scrutinized closely. You will bear the burden of proof to show that you have complied with the new law. I urge you to review your billing procedure accordingly. ◄

Ecology of health

There are some who may question whether physicians, or the medical profession for that matter, have any right or responsibility to concern themselves with such things as quality of life or living, the well-being of humanity as a whole, or the difficult problems of the earth ecosystem. But the evidence is at hand that the illnesses of the environment will surely become illnesses of man Whenever man becomes ill or is in danger of becoming ill, the physician inevitably becomes concerned not only with the cure but with the causes, and then with prevention of the illness. There are many examples. Physicians identified the need and pioneered programs for pure food and sanitation, as well as programs for specific disease control—malaria, for example. Occupational health for industry was physician-inspired, and physicians first promoted the use of seat belts to reduce injuries in automobile accidents. What is needed now is simply to do likewise for the health problems that now threaten humanity as a result of a very finite earth ecosystem relentlessly closing in upon an expanding human population with its swiftly developing world-wide technology and industry. (Malcolm S.M. Watts.: Ecological Health and Quality of Life Now and Forevermore. **California Medicine** (Nov) 1970, 113:5, pages 55-57.)

what goes on

a guide to continuing education

September 16-October 13—American College of Physicians

Regional Scientific Meetings

Sept. 17-18—*Wisconsin Regional:* Green Bay, Wis. Info write: Herbert W. Pohle, MD, 425 E. Wisconsin Ave., Milwaukee, Wis. 53202

Oct. 8-9—*Illinois Regional,* Peoria, Ill.; Info write: Richard Allyn, MD, 107 S. 5th St. Springfield, Ill. 62701

Oct. 8-9—*Kentucky/Tennessee Regional,* Louisville, Ky., Info write: George W. Pedigo, Jr., M.D., 670 Med. Towers, S. Louisville, Ky. 40202

Oct. 13—*Indiana Regional,* Indianapolis, Ind. Info write: Donald E. Wood, MD, 6325 Guilford, Indianapolis, Ind. 46220

September 17-19—Forest Hospital

Three-Day Symposium on Sex and Sensuality

The purpose of the symposium is to call attention to the best methods for dealing with individuals seeking help. For additional information contact: Dave Jacobson, Forest Hospital, 555 Wilson Ave., Des Plaines, Illinois or call (312) 827-8811.

Forest Hospital, Des Plaines, Illinois

September 23-October 21—Cleveland Clinic Educational Foundation

Sept. 23—*Medical Technology*
Oct. 6-7—*Psychiatric Aspects of Medical Practice for General Physicians*
Oct. 13-14—*Renal Disease—Practical Applications*
Oct. 20-21—*Clinical Aspects of Liver Disease*
For information and detailed programs write: Director of Education, The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland, Ohio 44106.

September 27-29—American Cancer Society and the National Cancer Institute

Seventh Annual Cancer Conference

All members of the medical and related professions are invited as well as research investigators and medical students. Preregistration is requested. For information write: Sydney L. Adje, MD, Coordinator, American Cancer Society, 219 E. 42nd St., New York, New York 10017

Biltmore Hotel, Los Angeles, California

September 30-October 2—American College of Chest Physicians

Pediatric Cardio-respiratory Case

Postgraduate course dealing with the practical aspects of pediatric cardio-respiratory disease. Nurses, inhalation and physical therapists with a special interest in pediatrics are invited. For information write: American College of Chest Physicians, Dept of Continuing Education, 112 East Chestnut St., Chicago, Illinois 60611

Houston, Texas

September 30-October 2—American College of Obstetricians and Gynecologists

District VI Annual Meeting

A seminar on perinatal medicine will be the central feature. In addition, a district nursing conference will be held in conjunction with the Fellows' meeting. For advance registration write: C. Weir Horswill, M.D., F.A.C.O.G., Central Arrangements chairman, University Hospitals, 1300 University Avenue, Madison, Wis. 53706.

Madison, Wisconsin

October 2-3—University of Iowa

Continuing Education Conference on Radiology

Saturday morning courses will consist of refresher courses on mammography, radiation, therapy, nuclear medicine, and head and neck, pediatric and chest radiology. Afternoon topics will include radiology of juglar tumors, radiolucent defects in the renal pelvis, and pre-operative radiation therapy for oral cavity cancer. Guest members will be John P. Dorst, MD,

John Hopkins University, and Thomas F. Meany, MD, Cleveland Clinic.
For information on this conference and others write: Director of Continuing Medical Education, Office of the Dean, The University of Iowa, Iowa City 52240.

University of Iowa Health Center, Iowa City, Iowa

October 2-30—American Society of Anesthesiology

Oct. 2—*Postgraduate Course on Obstetric Analgesia & Anesthesia*
Boston Hospital for Women, Boston, Mass.

Oct. 16-20—*Annual Meeting*
Atlanta, Georgia

Oct. 30—*Third Annual Symposium on Respiratory Failure*
Friendship International Hotel, Baltimore, Maryland
For additional information write: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, Illinois 60068.

October 4-9—Abraham Lincoln School of Medicine-Dept. of Otolaryngology

Laryngology and Broncholsophalgology
This course is limited to 15 physicians and will be under the direction of Paul H. Holinger, M.D. It will include visits to a number of Chicago hospitals. Interested registrants write: Dept. of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois, P.O. Box 6998, Chicago, Illinois

University of Illinois Eye and Ear Infirmary

October 5-7—Veterans Administration

18th Spinal Cord Injury Conference

The Department of Surgery will hold a joint conference with the International Medical Society of Paraplegia. For information, registration or application of presentation for papers write: Dr. Erich G. Krueger, Director, Spinal Cord Injury Service, (127) VA Central Office, 810 Vermont Avenue, N.W., Washington, D.C. 20420

Jimmy Fund Auditorium/Childrens Hospital Medical Center Boston, Massachusetts

October 5-10—Society for Clinical Experimental Hypnosis

23rd Annual Workshop & Scientific Program

Workshops will be held concurrently. There will be both introductory and advanced workshops on hypnotic induction and deepening techniques. The Scientific Program (8-10) will have paper sessions and Symposia will be offered. For information write: Mr. Claude Weil, SCEH Convention 1971, Center for Continuing Education, University of Chicago, 1307 E. 60th St., Chicago, Illinois 60637

University of Chicago, Chicago, Illinois

October 6-7—Health Industries Association

Third Annual Symposium

This symposium will feature discussions and technical presentation on sterilization and the sterility of disposable medical devices. Program and details can be obtained by writing: Sterile Disposable Device Committee on HIA, Suite 314, 1225 Connecticut Avenue, N.W., Washington, D.C. 20036 or call (202) 659-4610

Hotel Sonesta, Washington, D.C.

October 8—Association of American Physicians and Surgeons

Annual Meeting

Major address given by J. Enoch Powell, former British Minister of Health, on the other side in the medicine story. For further information write: Frank K. Woolley, AAPS, 230 N. Michigan Avenue, Chicago, Illinois 60601 or call days (312) 782-5569, nights (312) 355-0150.

Colony Motel, Clayton, Missouri

October 8-9—American College of Physicians

Scientific-Educational Meeting

Two lectures will highlight the scientific program: one is the "Development of New Drugs: The Past, the Present and The Future" by Kenneth G. Kohlstaedt, M.D., vice-president of the A.C.P. and vice-president for medical research of the Eli Lilly Company; the other lecture is "Education of Medical Educators" by Michael J. Halberstam, M.D.
For information contact: Richard Allyn, M.D., 107 S. 5th St., Springfield, Ill. 62701.

Voyager Inn, Peoria, Illinois

October 10-15—American Society of Clinical Hypnosis

14th Annual Scientific Meeting

Members and non-members, physicians, dentists and specialists in related fields may attend. The workshop is acceptable for 23 accredited hours. There will also be special activities for the ladies. For information write: American Society of Clinical Hypnosis, 800 Washington Avenue, Southeast, Minneapolis, Minnesota 55414

Pick Congress Hotel, Chicago, Illinois

October 13-14—Health Professions

Non Surgical Medical Emergencies

Departments of medicine, pediatrics and psychiatry are cooperating to present the latest information concerning the care of patients with non-surgical emergencies. For information write: University of Missouri, School of Medicine, Committee on Continuing Medical Education M-175 Medical Center, Columbia, Missouri 65201

October 13—University of Chicago

New Developments in the Management of Anemias

The first in a series of nine sessions on clinical applications. Fee for the entire series is $100; for a single session, $15. Medical faculty from the Division of

Biological Sciences and the Pritzker School of Medicine of the Univ. of Chicago, and selected non-university specialists will lecture on topics ranging from prenatal diagnosis of hereditary disorders to diabetes.

Frank Billings Auditorium, 950 E. 59th Street, Chicago, Illinois

October 15—Mississippi Valley Thoracic Society

Scientific Meeting

Medical sessions will be open to general practitioners, internists and specialists in pulmonary disease. Speakers will be: Dr. Drew Miller, Mayo Clinic; Dr. Roy V. Lourenco, Univ. of Ill. College of Medicine; Dr. George N. Bedell, Univ. of Ia. College of Medicine; Dr. Stuart Brooks, Univ. of Cincinnati College of Medicine; and Dr. Gerald L. Baum, Case-Western Reserve School of Medicine, Cleveland.
For further information and reservations write: The Tuberculosis Institute of Chicago and Cook County, 1440 W. Washington Blvd., Chicago, 60607.

October 16-17—UCLA Extension Continuing Health Sciences and UCLA School of Medicine

Clinical Aspects of Pediatrics Neurology

Lecture topics will include, "Who is 'At Risk' Newborn;" "Ataxia in Children;" "New Advances in Inborn Error Affecting the Central Nervous System;" "Pseudodegenerative States in Childhood;" and "Head Injuries in Children." Guest speakers: Patrick Bray, MD, professor and chairman department of neurology, Kentucky; and John S. O'Brien, MD, professor and chairman of neuro-sciences, California. For additional information write: Donald Brayton, MD, Director, Dept. of Continuing Education in Health Sciences, Room 15-39, Rehabilitation Center, University Extension, UCLA Los Angeles, California, 90024, or call Mrs. Elizabeth Gifford (213) 825-7186

Auditorium/Neuropsychiatric Institute at UCLA

October 15-16—Midwest Population Center of Chicago and Vasectomy Services, Inc.

First National Conference of Vasectomy

Speakers will include Able Leader, MD, Houston; Helen Edey, MD, New York; Mathew Freund, MD., New York, Ronald Elson, MD., Chicago, and Warren Hearn, MD., Washington.
Registration fee: $25. For further information write: Don C. Shaw, Executive Director, Midwest Population Center, 100 East Ohio St., Chicago, Illinois 60611

Sheraton-Chicago Hotel, Chicago, Illinois

October 16-17—American Society of Anesthesiologists

Twenty-second Annual Refresher Course Lectures

There are 53 lectures to be given on 46 topics. Reservations at the earliest possible date. For information write: The American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, Illinois 60068

Atlanta Marriott Motor Hotel, Atlanta, Georgia

October 16-21—American Academy of Pediatrics

Fortieth Annual Meeting

Meeting will feature a versatile program of scientific presentation, seminars, round tables, & symposiums including: seven symposiums during general sessions on teen-age pregnancy, behavior modification by drugs; divorce, its effect on children; immunization progress and problems; environmental hazards; mists; aerosal and oxygen, and exciting new developments in pediatrics. Approximately 133 papers on all facets of pediatrics; 17 round-table discussions covering such subjects as family therapy, seizures, allergy, failure to drive; 18 seminars covering areas of pediatrics. Several special sessions including a symposium on children's television programming, 12 motion picture films. For information write: Dept. of Public Information, 1801 Hinman Avenue, Evanston, Illinois 60204 or call (312) 869-4255.

October 18-22—American College of Surgeons

Fifty-seventh Annual Clinical Congress

Features will include "Forum on Fundamental Surgical Problems;" 17 postgraduate courses given for younger surgeons; more than 45 panel discussions & symposia on current problems in general surgery; 90 motion picture films; a review of "What's New in Surgery;" Closed circuit telecasts of actual operations from Thomas Jefferson Hospital, Philadelphia; 450 scientific exhibits; special sessions on cancer, trauma, and undergraduate surgical education; session on professional liability; and a session on the surgical education and self-assesment program of the college to help fellows (members) & other qualified physicians evaluate the extent of their basic clinical knowledge in surgery. For further information contact: Sara Barr Cohen, Director of Publications, American College of Surgeons, 55 E. Erie Street, Chicago, Illinois 60611

Atlantic City, New Jersey

October 22—ISMS Committee on Nutrition
Nutrition Symposium

Ramada Inn, Peoria Illinois

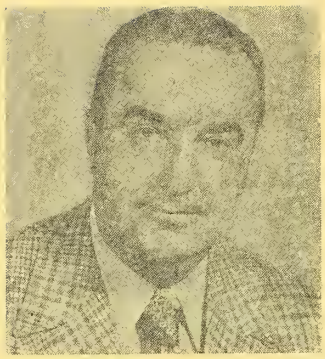
October 23-29—Abraham Lincoln School of Medicine/Department of Otolaryngology
Annual Otolaryngologic Assembly

A condensed postgraduate, basic and clinical program for practicing otolaryngologists under the direction of Emanuel M. Skolnik, MD. Designed to bring specialists current information in medical and surgical otorlaryngology. Direct inquiries to: Otorlaryngology, P.O. Box 6998, Chicago, Illinois 60680

University of Illinois

(Save for reference)


REPORT
ON LEGISLATION
Rx
Rx



Analysis of key medical legislation . . .

LEGISLATORS AND OTHER ELECTED OFFICIALS at all levels of government are becoming more and more concerned about health care delivery. Spiraling costs, manpower shortages, advanced techniques and new procedures have caught the attention of nearly everyone in government.

This overriding concern for improved health care delivery uniformly throughout society is reflected in the state legislative process. Nearly ten percent of all legislation considered by the Illinois House and Senate between January and July of this year was watched by the ISMS Governmental Affairs Council. This means approximately ten percent of the legislation introduced and considered affected the medical profession in some form or another.

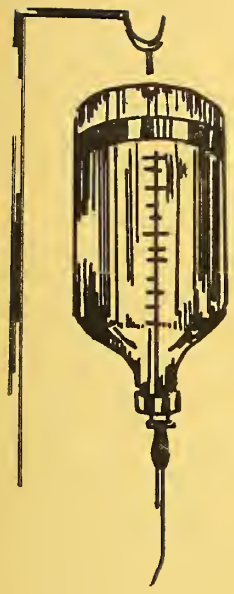
This increased activity in the legislative sphere means more activity on the part of physicians throughout the state. The legislative record compiled so far during the 77th General Assembly by the Illinois State Medical Society is an impressive one. Any success we have achieved could not have been possible without the active participation of physicians who provided expert testimony on behalf of or in opposition to bills in committee hearings. It could not have happened without the aid of physicians who provided a review and analysis of complicated, technical legislation. It could not have happened without physicians who became involved to the point of contacting their legislators to present medicine's point of view.

All too often physicians—as is the case with all humans—shy away from that which is confusing. Government is big; government is confusing. However, understanding comes with involvement. There is nothing more gratifying than to watch a physician testify at a committee hearing in Springfield and then stay to watch what is happening out of an inherent fascination with the process. When he sees what it is all about, the physician finds he not only understands government but he also enjoys it.

Following is an analysis of key medical legislation passed by the Illinois General Assembly between January and June of this year. Legislation which is still pending or legislation which was defeated is not included in the analysis. Most of the bills have been signed by Governor Ogilvie and are law; some have not yet been signed.

The analysis is presented to help you keep abreast of the changes in law affecting the practice of medicine. Some significant changes have been made, and you should be aware of them. If you have any questions, I encourage you to call the ISMS Division of Legislation and Public Affairs to obtain the answers.

Alfred J. Faber, M.D.
Chairman
Governmental Affairs Council



Legislation Answers Blood Hepatitis Decision

The General Assembly has given medicine two years to devise a reliable test to detect the presence of serum hepatitis in blood.

The Illinois State Medical Society, the Illinois Hospital Association and many other organizations endorsed House Bill 16, which relieves blood donors, physicians, hospitals and blood banks from liability in giving transfusions. Legal liability was imposed by the Illinois Supreme Court in the *Cunningham v. MacNeal Memorial Hospital* decision.

The original bill was written to grant immunity from liability—except in cases of negligence—for blood transfusions and the implantation of any other tissues or organs. It did not contain an automatic expiration date.

Attorneys serving on the House judiciary committee, however, amended the bill several times and added a clause ensuring automatic expiration of the law on July 1, 1973. Their explanation is that a grant of timeless immunity would relieve the medical community of the urgency to find a reliable test to detect serum hepatitis in blood.

If a reliable test is not found before January, 1973, it will be necessary to return to the legislature to seek the adoption of additional legislation extending the time period or eliminating the time requirement.

Fee-Splitting Outlawed

Fee-splitting is now illegal as well as unethical in Illinois.

A new law already signed by Governor Ogilvie defines fee-splitting as "directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered," and makes fee-splitting grounds for license revocation.

In addition, a loophole in Internal Revenue Service regulations was plugged with the enactment of this law. Although fee-splitting is unethical, IRS permitted physicians to deduct "kick-backs" from their income tax return as long as fee-splitting was not illegal in their state. Such deductions no longer can be made by Illinois physicians.

The law applies not only to agreements between physicians but also to agreements between physicians and clinical laboratories, optical houses, pharmacists, surgical supply houses and X-ray laboratories.

The bill was amended at ISMS' request to exclude fees paid to members of medical corporations or group practices which are then put into a common pool and shared by all participants in the corporation. It was also amended so that two or more physicians participating in a single case could share a fee in proportion to the services performed and responsibilities assumed by each. In such a case the patient must be aware of the division of the fee and the proportion going to each physician.

A business manager's analysis of this legislation can be found on page 228 of this journal.





Urge Drug Labeling for Safety

The General Assembly has passed three bills which require the labels on all prescription items to contain the name of the medicine, dosage and quantity. The bills are currently awaiting Governor Ogilvie's signature.

The bills apply to dispensing physicians as well as pharmacists. Physicians will be required to attach to any prescription a label indicating the date on which the medicine was dispensed, the last name of the dispensor, the directions and the proprietary name/s, or the established name/s of the drug, the dosage and the quantity.

The only exemption to the labeling requirement exists when the physician specifies in writing that "the health of the person to whom the drug or medicine is dispensed requires that such information be omitted."

Also exempted from the requirements are samples and "starters" which are already labeled in conformance with the Federal and Illinois Food, Drug and Cosmetic Acts, and are dispensed without charge.

Legislation O.K.'s Treatment for Teen Addicts

In answer to widespread drug abuse among teens, legislation has been enacted which encourages teens to seek treatment in confidentiality.

The bill, signed by the Governor on August 16, will permit minors 12-years-of-age or older to consent to medical care when they are suffering from the use of depressant or stimulant drugs or hard narcotic drugs.

Once given, the minor's consent is binding and valid.

The physician diagnosing or treating the teen for drug abuse is not required to report the case to the Department of Public Health, as is the case in treating venereal disease. He may—but is not obligated to—report the treatment to the child's parents.

State Acts to Increase Health Manpower

The physician shortage in Illinois received its share of legislative attention during the past session. Successful approaches to solving the problem generally took the form of eliminating antiquated licensure requirements or encouraging qualified personnel to emigrate to Illinois.

The Medical Practice Act requires that a medical practitioner must be of good moral character to practice medicine in Illinois. Legislation passed both House and Senate which authorizes the Department of Registration and Education to investigate the background of an individual with a felony conviction and to grant him a license if he has been sufficiently rehabilitated to warrant the public trust.

Also eliminated from the licensure section of the Medical Practice Act was the requirement that an applicant for licensure be a citizen of the United States or be in the process of gaining his citizenship.

Due to the quota system, qualified physicians are prevented from obtaining licensure when they have been unable to receive immigration numbers from their home countries. Now they may be licensed after passing the medical licensure examination upon signing an affidavit stating they will become U. S. citizens within a five



year period. If a physician obtaining licensure under this act fails to perfect his citizenship within five years, the Department must revoke or refuse to renew his license until he attains final citizenship .

The Medical Practice Act also was amended to provide a means for preventing duplication of course work on the part of medical students.

Legislation already approved by Governor Ogilvie gives the Department of Registration and Education, at the recommendation of a medical school dean, the authority to grant a student advanced standing in medical school.

The thrust of this ISMS-instigated legislation is two-fold: it permits medical schools to grant credit to applicants who have done extensive course work in related fields such as biology and chemistry; and it also permits educators to fill medical school vacancies with students who enrolled in foreign medical schools when they were not admitted to Illinois medical schools.

Rather than starting medical training over again, these students would receive partial credit for some of the equivalent courses they took in the foreign schools.

Finally, the Ogilvie administration presented its contribution to solving the physician shortage problem by sponsoring legislation which would permit physicians licensed in states sharing reciprocity with Illinois to practice in Illinois for up to six months while taking and passing the reciprocity examination.

Governor Ogilvie already has signed this bill into law, and the Medical Examining Board met August 5 to promulgate rules for the Department to follow in implementing the legislation. Among the operational procedures outlined at this meeting are the following:

★ A physician applying for reciprocity and wishing to begin practice before taking the exam may not begin practicing until notified by the Department that his application is in order. The notification will specify a date on which he may begin to practice.

★ Once a physician has failed the exam he must discontinue practice, regardless of any time remaining in the six-month period.

★ Any candidate who has ever taken and failed either the reciprocity exam or the full exam will be ineligible to take advantage of the provisions of the six-month licensure program.

★ A candidate will be expected to take the first examination given by the Department after he has been granted permission to practice consistent with the reciprocity regulations.



The Board then directed the Department's legal counsel to devise any additional operating rules and regulations which may be necessary.

Close cooperation between the Department and ISMS was necessary to see this bill passed by both houses of the legislature, but it appears as if this single piece of legislation will attract its share of physicians into Illinois.

State's Attorneys Push Reporting Law

Part of the Illinois State's Attorneys association law enforcement package was a reporting bill aimed at physicians. Objectionable aspects were amended out of the bill at ISMS request.

When the bill is signed by Governor Ogilvie, it will be the duty of any physician, nurse or person operating a medical facility to notify a local law enforcement agency "as soon as treatment permits" when a person requesting treatment has received an injury resulting from the discharge of a firearm or an injury sustained in the commission of or as a victim of a criminal offense.

Reporting the application for treatment is not necessary if the individual is accompanied by a law enforcement officer.

Another reporting bill in a similar vein requires physicians to report to local law enforcement officials cases in which a child dies from apparent injury, neglect or malnutrition before being found or brought to a hospital.

Formerly, the Battered Child Act required a physician to report such cases if the child was alive but did not require the report to be made if the child was dead. The recent enactment corrects this deficiency in the law.

New Law Encourages Impartial Peer Review

Legislation signed by Governor Richard B. Ogilvie on July 26, will encourage physicians serving on peer review or medical review committees to be more impartial in their judgments.

The law amends the Medical Practice Act to grant physicians serving on these committees immunity from civil liability arising from their decisions while serving on the committees. The immunity, however, does not cover any action which involves wanton or willful misconduct.

ISMS Bill Extends School Physical Period

School physicals for children entering kindergarten, first, fifth and ninth grades may be extended throughout a six-month period as a result of the enactment of this ISMS-instigated bill.

The school code required the physicals to be performed "immediately" upon entering those grades, and some local school superintendents decreed "immediately" means the month before the fall semester begins.

The new law should space the examinations over a longer period of time, thus freeing the physician's office of the August congestion so prevalent in many areas.





Support Bill to Insure Psychiatrist-Patient Confidentiality

The Illinois State Medical Society worked closely with members of the Illinois Psychiatric Society for passage of legislation which will protect the confidentiality of patients' records in civil cases falling within the Divorce Act.

The legislation, which has not yet been approved by the Governor, amends the Evidence and Depositions Act. The act presently states there is no privileged communication between patient and psychiatrist when a patient introduces his mental state as an element of his claim or defense in a civil or administrative proceeding.

The practical effect of this exemption to privileged communication status is to inhibit patients from seeking therapy or to force a choice of not filing suit or of disclosing very personal but often-times irrelevant information in court.

After adoption of a Senate amendment, the bill maintains confidentiality in civil suits falling within the jurisdiction of the Divorce Act unless the patient introduces the communication as evidence to prove his mental condition. When the patient utilizes the communication as proof, it is open for investigation to other parties in the case.

The legislation helps protect psychiatrist-patient confidentiality, while at the same time it does not violate the principle of fairness essential to the adversary process.

Eye Screening Mandatory for School Children

Vision screening tests now are mandatory for all school children. A bill signed by Governor Ogilvie provides that the tests can be performed by a registered nurse or other qualified person, but if an abnormality is detected the child must be referred to an ophthalmologist or optometrist.

Governor Signs CHP Proposal

Governor Ogilvie has signed a proposal which places comprehensive health planning emphasis on the local level.

In addition to establishing a state comprehensive health planning agency outside of the Governor's office and a state advisory council, the legislation provides matching fund grants to encourage the formation of county and multi-county regional health planning organizations.

Ogilvie Signs Drug Reform Bills

Gov. Richard B. Ogilvie on August 16, signed into law the Ill. Controlled Substances Act and the Cannabis Control Act.

Signature of the bipartisan legislative package achieves three major results in the fight against drug abuse:

- It provides realistic penalties to be applied against the chance user.
- It provides a distinction between marihuana, a variety of amphetamines, barbiturates and hallucinogens, and heroin and other "hard" narcotics.
- It provides increased penalties for sellers, distributors and others profiting from the drug traffic, especially those selling to minors.

Representing ISMS at the formal bill-signing ceremony in the Governor's Chicago office was Marshall Falk, M.D., chairman of the Council on Mental Health and Addiction.

Follow ISMS Policy

The Cannabis Control Act establishes a penalty structure for the use and sale of marihuana consistent with the ISMS position of decreasing penalties for users and increasing penalties for "pushers."

The Controlled Substances Act establishes five schedules into which all drugs can be placed. The Director of the Department of Law Enforcement assigns the substance to the category, but his decision will not be effected until approved by the Dangerous Drugs Advisory Council.

Each rule formulated by the Director and approved by the Council must then be submitted to the General Assembly for concurrence. The General Assembly has two years in which to concur. If it fails to do so, the rule expires.

List Five Schedules

Each of the five schedules has criteria to be used in evaluating the classification of drugs. Following is a list of the schedules and their criteria:

- *Schedule I* includes those substances with a high potential for abuse with no accepted medical use in treatment. Included in this schedule are heroin and LSD.
- *Schedule II* includes those substances with a high potential for abuse, accepted medical use in treatment and abuse leading to severe psychological or physiological dependence. Included in this schedule are opium, cocaine and methadone.
- *Schedule III* includes those substances with a potential for abuse less than those in Schedules I and II, having accepted medical use in treatment and abuse leading to moderate or low physiological dependence or high psychological dependence. Depressant and stimulant substances as well as preparations containing limited quantities of narcotic drugs fall into this schedule.
- *Schedule IV* includes those substances having a low potential for abuse relative to substances in Schedule III, having accepted medical use in treatment and abuse leading to limited physiological dependence or psychological dependence relative to substances in Schedule III. Among the substances in this category is phenobarbital.
- *Schedule V* includes those substances having a low potential for abuse relative to the controlled substances in Schedule IV, having accepted medical use in treatment and abuse leading to limited physiological dependence or psychological dependence relative to Schedule IV substances. Included in this schedule are not more than 200 milligrams of codeine or not more than two grains of opium.

Report on Legislation

Practitioners to Register

Practitioners must be registered to dispense any controlled substances in Schedules II through V, which is automatic to persons registered under Federal law after the practitioner sends a current copy of his Federal registration to the Department of Registration and Education. Federal law dictates the transference of substances in Schedules I and II.

Prescriptions for Schedule II substances must be written in triplicate on forms obtainable in a numbered series of 100 from the Department of Law Enforcement for $3 per group. (See page 222 for additional information.)

Prescriptions of Schedule III through IV substances may be written in the customary manner. They may not be filled or refilled more than six months after the prescription date, nor may they be refilled more than five times unless renewed, in writing, by the practitioner.

The Illinois Controlled Substances Act repeals and replaces the Uniform Narcotic Drug Act and the Drug Abuse Control Act.

"Home Rule powers"

(Continued from page 221)

To prevent this from happening, ISMS joined other professional groups in supporting a legislative effort (H.B. 1553) prohibiting home rule units from licensing professions already licensed by the state.

The bill passed the House but failed to achieve the required 30 votes in the Senate. Another try at passing the bill will be made during the coming Fall session. It is evident we will need all the help we can muster to be successful.

What can the individual physician do to help? Be alert to what is happening in your local home rule unit. If the city council institutes licensing, contact other professional groups affected by the action and begin injunctive proceedings. This will give us time to maneuver successful legislation in Springfield. Talk to your state senator. Tell him you want to see H.B. 1553 enacted. Tell him you want *all* home rule units in the state covered by its provisions. Advise the ISMS Division of Leg. & Public Affairs if a local home rule unit takes steps to pass a licensure measure.

Imposing curbs on home rule units will be difficult, but it can be done if enough people are involved. The ISMS Governmental Affairs Council will do what it can to educate and promote within the society, but we need your help.

Measured by mortality

The adverse ranking of the U.S. among nations as measured by infant and maternal mortality is often noted. I personally am convinced that among the developed countries most of the international differences are not due to the number of health care providers or even health care systems. They are due to radical differences in socio-economic standards. Those countries which seem to do better than we, are not necessarily wealthier than we, but they have a more even distribution of their wealth. They may have proportionately as many rich people, but they certainly have fewer of the poor.

If we think national health insurance is going to wipe out the rich-poor gap as far as health is concerned, I think we are loading the system with an impossible goal. (Mark S. Blumberg.: View on National Health Insurance. **The Internist** (June) 1971, pages 3 and 4.)

Halotestin®
(fluoxymesterone, Upjohn)

Orally active androgen about 5 times as potent in anabolic and androgenic activity as methyltestosterone. Halotestin (fluoxymesterone) induces significant retention of calcium and potassium, but retention of sodium not marked. Doses below 20 mg. daily have little effect in producing creatinuria.
Indications *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.
Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.
Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.
Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.
Supplied *Tablets: 2 mg.*, scored—bottles of 100./ *5 mg.*, scored—bottles of 50./*10 mg.*, scored—bottles of 50.
For additional product information, see your Upjohn representative or consult the package circular.

Upjohn The Upjohn Company, Kalamazoo, Michigan

JA68-7627-R MED 8-5-S (LQX)

The FDA and physicians

(Continued from page 196)

standards as to safety and effectiveness, there is no patient convenience and economy in taking an irrational or even harmful drug mixture.

As we have indicated, we are not against fixed dose combinations. There is now and always will be a place for good combination drugs.

Our policy on drug combinations is remarkably simple to state and to defend. The fundamentals are: that more than one drug should not be used when one is all that is needed; that drugs in fixed combination should satisfy the needs of a population of patients who require concomitant treatment by the two or more drugs in the combination; that there be no incompatibility between the components; that the dose of such components be appropriate for the intended patients. In addition, a combination is appropriate when the added ingredient enhances the effectiveness of the main active ingredient and when an added ingredient minimizes the potential for abuse of the main active ingredient.

There can be no serious medical dispute about this. The Council on Drugs of the American Medical Association, the Council on Drugs of the American Pediatrics Association, the American Pharmaceutical Association, the *United States Pharmacopeia*, leading textbooks, and the leaders of the medical profession have consistently expressed the need for a sound medical rationale for using drugs in fixed combination.

We trust that you will agree that the above requirements are reasonable and, if followed, will help bring about better therapeutics and the availability of better drugs.

We recognize the need for us to put before the profession what is actually being proposed so that the physician can speak to it rather than to something that has not been proposed.

We will welcome your response after considering the points we have made.

Sincerely yours,
Charles C. Edwards, M.D.
Commissioner of Food and Drugs



report

a service of the american association of medical assistants, illinois society

We have a new name

By Ruby Jackson/Chicago Chapter

Well, not really a new name but it was decided at the recent Illinois State Convention in April, 1971 to use the American Association of Medical Assistants, Illinois Society name. This step was taken in an effort to promote unity and accord among our 13,000 plus members throughout the United States, Hawaii, Alaska and Puerto Rico.

Our aims, aspirations and goals have not changed. We still pledge to give undivided service to our physician employers and to increase this service through education. We are not now, nor shall be, a union.

Belonging to a professional organization is important and valuable because by belonging you continue to learn, improving your skills and keeping abreast of the new ideas in medicine.

Why not join your local chapter and take advantage of the services and benefits offered? By joining your local chapter you also become a member of the Illinois Society, receiving a state publication with many educational articles and news of other chapters. Our national organization, American Association of Medical Assistants, communicates our goals and efforts to other groups improving professional relations and securing financial support for our projects.

Remember the name, American Association of Medical Assistants, Illinois Society, which we bear with dignity and pride.

If you wish further information please contact Mrs. Norma Domanic, 150 Ash Street, New Lennox, 60451 or Mrs. Vivian Kraft, R.R. 2, Normal, 61761.

Inhalation therapy: Support of life

Inhalation therapy before the 1950's was virtually synonymous with oxygen therapy; it then became identified with the administration of intermittent positive pressure (IPPB). Contemporary inhalation therapy is not limited to a single mode of treatment. It should be a physiologically oriented systematic form of therapy designed to improve ventilation, distribution of impaired gas, airway resistance, mucociliary clearance and work of breathing in patients with respiratory disorders. Inhalation therapy involves the support of life in cardiorespiratory emergencies. In patients with chronic lung disease, inhalation therapy provides some measure of symptomatic improvement and, in the broadest sense, partial relief of disability. Thus, reasonably administered inhalation therapy requires knowledge of clinical pulmonary physiology, nursing care, pharmacology, resuscitation and rehabilitation. That such knowledge is frequently not exercised by persons using this form of therapy is perhaps best illustrated by specific examples. (Thomas L. Petty.: Why Not Take Inhalation Therapy Seriously? **Chest** (Editorials) 57:5 (May) 1970, pages 403-405.)

socio-economic news

a service of the division of health care delivery

By Joseph J. Lotharius

Assistant surgery fee increase requested

An increase in the minimum fee paid by the Illinois Department of Public Aid for physicians assisting in surgery was requested by ISMS Trustees. Presently, the minimum rate paid by IDPA is $25. ISMS thinks this minimum should be increased to $50 with additional payments allowed for lengthy operations. The Board's action was taken upon the recommendation of the Committee on Health Care Financing. A formal request for the rate increase has been submitted to IDPA.

Illinois FMC adopts by-laws And elects officers

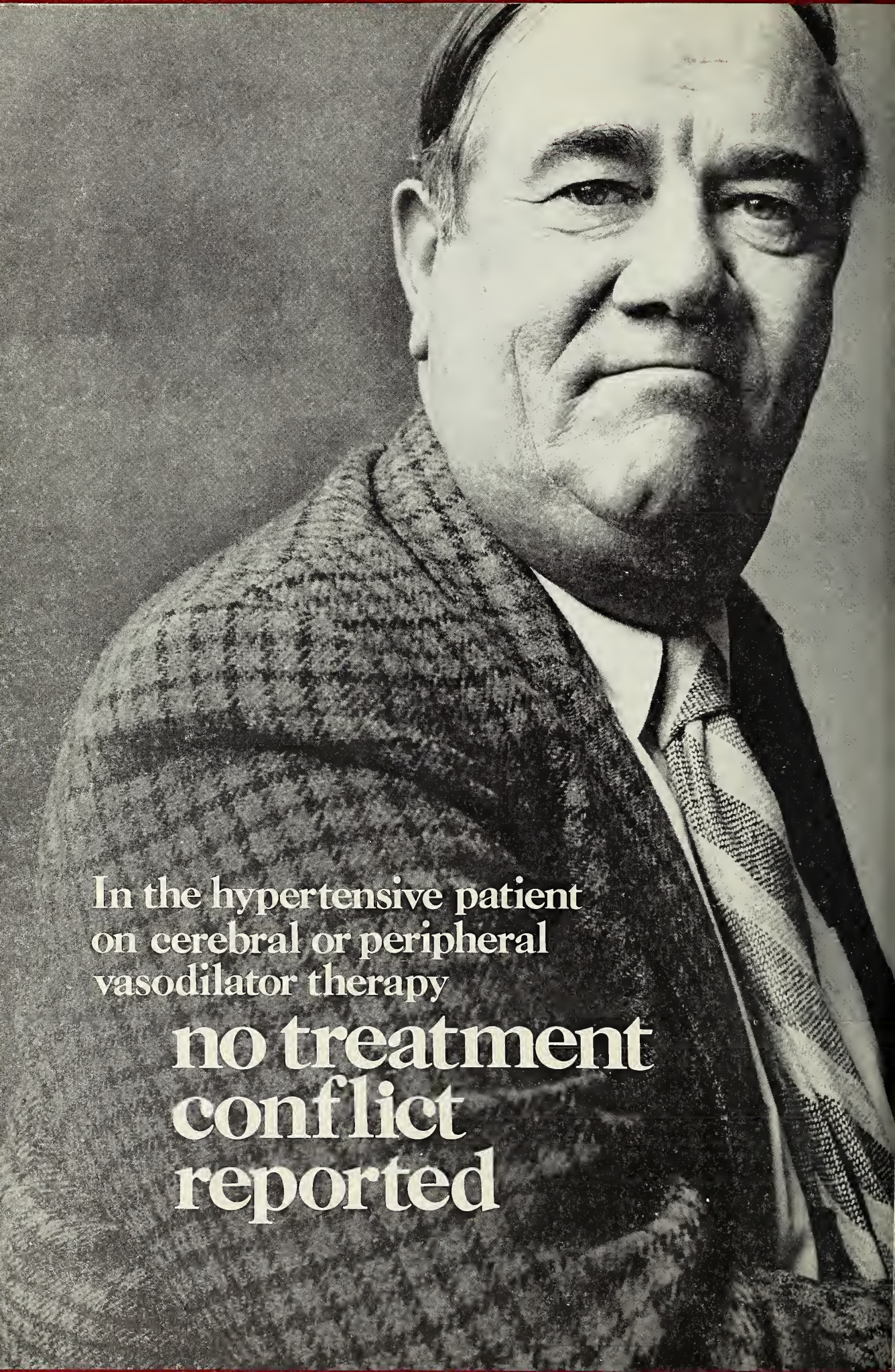
The recently established Illinois Foundation for Medical Care made significant progress at its first Board of Directors meeting. By-laws were adopted, officers were elected, an interim executive committee was named, and an executive vice-president was appointed to assume the administrative responsibilities of the Foundation.

Dr. Joseph R. O'Donnell, (Glen Ellyn) IFMC president, will appoint necessary FMC committees to function in such areas as benefit standards, norms of care and charge data. A Constitution & By-laws Committee will also be appointed to study the present by-laws and further spell out the relationship between the Illinois FMC and local foundations.

96% of Champaign County MDs join local FMC

Champaign County physicians gave almost unanimous endorsement to the Champaign County Foundation for Health Care when 96% of them applied for membership. The Illinois FMC and the Champaign Foundation are currently engaged in discussions with the Illinois Department of Public Aid. If negotiations are successful, Champaign Foundation physicians will implement a demonstration project for Medicaid. The Illinois FMC is developing statistics and actuarial data necessary for the Champaign Foundation to operate the Medicaid program on a prepayment basis.

(Continued on page 258)


In the hypertensive patient
on cerebral or peripheral
vasodilator therapy
no treatment
conflict
reported



VASODILAN®
(ISOXSUPRINE HCl)
the compatible vasodilator

- has not been reported to complicate the treatment of hypertension.
- conflicts have not been reported with concurrently administered antihypertensives, diuretics, corticosteroids or miotics.
- complications in the treatment of diabetes, peptic ulcer, coronary insufficiency, glaucoma or liver disease have not been reported.

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[1-4] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[2,4] and observation of clinical improvement.[1,3]
Composition: VASODILAN tablets, isoxsuprine HCl, 10 mg. and 20 mg. VASODILAN syrup, isoxsuprine HCl, 10 mg. per 5 ml. teaspoonful. Indications: *In cerebral vascular disorders,* for relief of symptoms due to vascular insufficiency associated with various conditions such as arteriosclerosis and hypertension. *In peripheral vascular disorders,* for relief of symptoms such as intermittent claudication, coldness, numbness, pain and cramping of the extremities—in the management of arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Dosage and Administration: In peripheral and cerebral vascular disorders—10 to 20 mg. three or four times daily. Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose. Supplied: *Tablets,* 10 mg.—bottles of 100 and 1000, and Unit Dose; 20 mg.—bottles of 100 and 500. *Syrup,* 10 mg. per 5 ml. teaspoonful—bottles of 1 pint.

References: 1. Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. 2. Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. 3. Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. 4. Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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the viewbox

(Continued from page 207)

DIAGNOSIS: *Granulomatous ileocolitis.* The radiographic features of granulomatous ileocolitis are essentially the same as seen in that disease with involvement of the small bowel. It usually will include skip lesions, deep ulcerations, transverse fissures, narrowing, stricture formation and soft tissue mass. The mucosal pattern may present with a coarse cobblestone appearance. The presence of internal fistulas to other loops of bowel or to the skin or urinary bladder are not infrequent. Characteristically, the right colon is involved as well as loops of small bowel. In a small percentage of cases, it is practically impossible to differentiate a diffuse granulomatous ileocolitis, involving the colon in its entirety, from ulcerative colitis. Microscopic confirmation is required to make a definite diagnosis. A differential diagnosis would include diverticulitis, carcinoma, foreign body perforation, and infarction of bowel. Complete obstruction is rare in granulomatous disease despite the fact that short segments may become markedly narrow. In ulcerative colitis the small bowel involvement is usually limited to the terminal ileum.

ekg of the month

(Continued from page 213)

ANSWER: C. Hyperkalemia. Serum potassium taken soon after the electrocardiogram was 7.2 mEg./L. The characteristic ECG abnormality is the tall narrow base, peaked T waves seen in most leads. Tall T waves may also be seen in inferior wall ischemia or infarction but are usually localized to V_1 through V_4 and associated with deep T wave inversion in leads II, III and AVF.

The treatment consisted of withholding further KCl administration, increased fluids and enemas with K-exchange resin (Kayexalate*).

**Produced by Winthrop Laboratories*

Lung tumor . . .

(Continued from page 212)

References

1. Hudson, Theodore R., Head, Jerome R., Head, Louis R., and Head, James M.: "Etiology of coin lesions," *Quart. Bull.*, Northwestern University Medical School, Chicago, 34:2, p. 146, 1960, Summer Quarter.
2. Turner, M., and Gallager, H. S.: "Occult appendices carcinoid," *Arch. Path.*, 88:2, p. 188, August 1969.

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.

Introducing

K-LYTE®/Cl

Each dose in solution supplies 25 mEq. potassium chloride

potassium supplement with chloride

The good-tasting way to treat hypokalemias induced by thiazide diuretics and other drugs...

Here, at last, is a potassium chloride supplement that just doesn't taste like one! The mixed fruit flavor of new K-Lyte/Cl is truly refreshing. Now, K-Lyte/Cl offers your patients all of the therapeutic advantages you expect from a potassium chloride supplement. And you can be sure that your patients will take the K-Lyte/Cl you prescribe—all in good taste.

Now you have a choice...

When extra chloride is not desired, original effervescent K-Lyte is unsurpassed in flavor, effective and safe in short- or long-term potassium supplementation. There is little chance of taste fatigue from K-Lyte with two delicious, effervescent flavors to alternate...fresh-tasting orange and sparkling lime.

K-Lyte® Each effervescent tablet in solution supplies 25 mEq. potassium as bicarbonate and citrate

K-Lyte®/Cl Each dose of powder in solution supplies 25 mEq. potassium chloride

Each tablet or dose must be completely dissolved before taking.

Indications: K-Lyte and K-Lyte/Cl are oral potassium supplements for therapy or prophylaxis of potassium deficiency. Particularly useful when thiazide diuretics or corticosteroids cause excessive excretory potassium losses. **Contraindications:** Impaired renal function with oliguria or azotemia; Addison's disease; hyperkalemia from any cause. **Warnings and Precautions:** Since the amount of potassium deficiency may be difficult to determine accurately, supplements should be administered with caution, and dosages adjusted to the requirements of the individual patient. Potassium intoxication rarely occurs in patients with normal kidney function. Symptoms of potassium intoxication are variable. They include listlessness, mental confusion, and tingling of the extremities. Frequent checks of the clinical status of the patient, ECG, and serum potassium level are desirable. In established hypokalemia, attention should also be directed toward other potential electrolyte disturbances. Potassium supplements should be given cautiously to digitalized patients. To minimize the possibility of gastrointestinal irritation associated with the oral ingestion of concentrated potassium salt preparations, patients should be carefully directed to dissolve each dose completely in the stated amount of water. K-Lyte/Cl contains 4.9 grams (20 calories) of sucrose per dose which should be considered for patients with restriction of caloric intake. **Adverse Reactions:** Nausea, vomiting, diarrhea, and abdominal discomfort may occur with the use of potassium salts. **Dosage and Administration:** Adults: 1 tablet or dose *completely dissolved*, 2 to 4 times daily, depending upon the requirements of the patient: K-Lyte: 1 tablet (25 mEq. potassium) in *3 to 4 ounces of cold or ice water;* K-Lyte/Cl: 1 dose (25 mEq. potassium chloride) in *6 ounces of cold or ice water.* The normal adult daily requirement is approximately 50 mEq. of elemental potassium. NOTE: *It is suggested that these products be taken with meals and sipped slowly over a 5-10 minute period.* **How Supplied:** K-Lyte: Effervescent tablets—boxes of 30 and 250 (orange or lime flavors). K-Lyte/Cl: Powder, cans of 30 measured doses with scoop (fruit-punch flavor). ℞

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Send samples of Alpha-Keri bath oil.

DR._____

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CITY STATE ZIP

Adolescent nutrition

(Continued from page 220)

What they need and will eat is not always available to them at places and times when they do eat.

(4) Many persons who are in strategic positions to help them are not knowledgeable about practical nutrition.

Some are actually misinformed; that includes too many physicians who received approximately two hours or less of practical nutrition in four to eight years of medical training.

The doctor who deals with adolescents should not hesitate to look for help from dietitians if he senses the need. He should, in dealing with adolescents, be knowledgeable, reasonable, and authoritative in offering nutrition guidance. He should realize that the adolescent is a budding individual struggling to establish a life style of his own. Whereas the adolescent once had a rigid pattern to rebel against, however, his parents today may be among the millions of Americans for whom meal patterns can hardly be called patterns at all. ◄

Socio-economic news

(Continued from page 251)

A consent form For dispensing the pill

ISMS members will soon be able to request legal consent forms for use when dispensing birth control pills. ISMS Trustees asked that such consent forms be prepared and made available to members because of recent adverse court decisions against physicians prescribing the pill. Consent forms can be ordered after September 30, from ISMS, 360 N. Michigan Ave., Chicago, Ill. 60601, Attn.: Jacob E. Reisch, M.D., Secretary-Treasurer.

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Second class postage paid at Chicago, Ill. and at additional mailing offices. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

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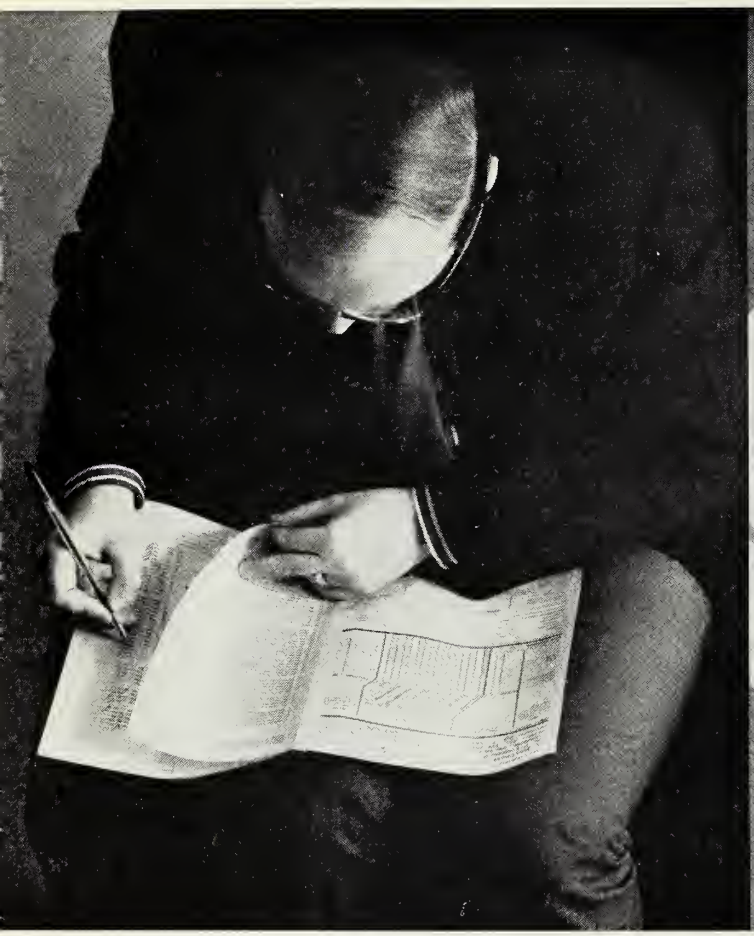
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REGISTERED AIA MEDIA DATA FORM

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New products to help improve patient care while providing more effective use of office time

The Rocom™ Medical Management System...





Rocom Health History System -- provides maximum screening information about the patient with a minimum expenditure of your time. Prior to your examination, the patient answers 129 carefully chosen questions arranged by body system. Only positive answers transfer through to the summary sheet. You get an immediate picture of the patient's current complaints with the assurance that all important screening questions are covered.

Rocom Medical Record System -- a simp but comprehensive method for keeping a complete record on every one of your patients. Permits to review a patient's medical history in second and retrieve information quickly. Can be used the "problem-oriented" method of keeping patien records. Color coding eliminates the likelihoo of misplaced files. A disease cross-index card keeps track of all patients with the same disea Well-kept records can be one of the greatest deterrents to malpractice suits. The Rocom Med Record System helps protect your good name.

BLUE SHIELD REPORT FOR Illinois Physicians

Blue Shield Establishes Mobile Information Center

As part of our ever present effort to provide new and complete information on health care programs to the people of Illinois, Blue Cross and Blue Shield have recently established a Mobile Information Center. Housed in a distinctive blue and white van, the Mobile Information Center is traveling throughout the state bringing information on Blue Cross and Blue Shield to Illinois residents.

Driven and staffed by Mr. Rich Ready, the MIC coordinator, the Mobile Information Center will appear at shopping centers, county fairs, public squares and Health Improvement Association enrollments in all parts of Illinois. From November to mid-February, the Center will remain in the Chicago area. The rest of the year it will tour the northwestern counties and the downstate area. The Center will spend a great deal of time in southern Illinois where residents do not have as great an opportunity to talk with Plan representatives as those who live near our Chicago office do.

Pre-arrival announcements of the Center's scheduled appearance will be made over the radio and in local newspapers. The Center will be open from 9 A.M. to 5 P.M. at every scheduled stop.

Mr. Ready will be available to talk to people about Blue Cross and Blue Shield and to answer any questions they might have. Besides information on Blue Cross and Blue Shield benefits, the van will carry information on health care costs, programs, and services as well as numerous public health materials from a variety of agencies and professional associations.

As MIC coordinator, Mr. Ready will also answer questions about specific Blue Cross and Blue Shield claims. A radio-telephone will keep Mr. Ready in constant contact with the Blue Cross and Blue Shield headquarters in Chicago. There, on line computers can produce subscribers' records within seconds on television screens. Minutes later, whole histories can be transmitted by telephone to the van.

Commenting on the Mobile Information Center, which made its first appearance in early September, Blue Cross and Blue Shield Executive Vice President Robert M. Redinger stated, "We know the public is concerned about the financing aspects of hospital and surgical-medical care. We are trying to help by bringing our wide experience to bear on individual problems."

Chicago and Rockford Plans Merge

The Board of Trustees of the Medical Surgical Service of Illinois (Rockford Blue Shield) has announced its decision to merge with the Blue Shield Plan of Illinois Medical Service. The action was taken after intensive study and analysis revealed that the merger would be of great benefit to Blue Shield members and to the medical community.

The combination of resources of the two Plans would strengthen Blue Shield's ability to continue its support of the present voluntary health care system while looking ahead to the health care needs of the future. In addition, the merger permits us to broaden our marketing efforts in Illinois, to extend our professional relations activities, and to continue our efforts to be of constant service to the people of Illinois.

Additional Clarifications For FEP

Last month, the *Blue Shield Report* stressed some important requirements and limitations for coverage under the Federal Employee Program Service Benefit Plan. The following coverage stipulations are in addition to those previously mentioned:

—No benefits will be paid under FEP, as a rule, for a physician's claim if the hospital claim has been disallowed.

—Claims which are disallowed under the FEP Basic Benefits will no longer be covered by the Supplemental Benefits.

—Reports for long stay hospital cases will be required after 14 days rather than the current 30 days.

—Claims for private duty nursing, covered under the Supplemental Benefits, will have to show the medical necessity for such nursing, the level of "skilled" nursing provided, and the need for continuous skilled nursing care.

In the last two instances, physicians may be asked to furnish additional information.

(This is not an advertisement)

ASK BLUE SHIELD
• • • ABOUT MEDICARE

Coverage Of EKG'S In Independent Laboratories

Payment may be made under Part B Medicare for the taking of an electrocardiogram tracing in a Social Security Administration approved independent laboratory if:

1. The EKG is ordered by a physician;
2. The *interpretation* is performed by a physician; and
3. The person taking the tracing is a physician or meets at least the requirements of a laboratory technician or technologist as defined by the Social Security Administration.

Laboratories billing for both the taking and the interpretation of an EKG must identify the physician making the interpretation on the SSA 1490, Request for Medicare Payment form. In these cases, no separate bill for a physician's services will be allowed unless it is clearly indicated that the physician was the patient's attending or consulting physician.

A Medicare claim for an EKG, whether submitted by an attending physician, a patient, or an independent laboratory, must contain the following information:

1. The name and address of the referring physician.
2. In a nonemergency situation, a description of the patient's condition clearly indicating that the EKG was ordered for a covered diagnostic purpose and not as part of a routine examination.
3. In an emergency situation, i.e., where the patient is or may be experiencing what is commonly referred to as a "heart attack", evidence that a physician was in attendence at the time the service was performed or immediately thereafter.

In addition, the independent laboratory is required to maintain a file containing the written referral or order of the physician and the name of the person taking the tracing as well as all the information listed above as necessary on a claim.

The following independent laboratories have recently received Social Security Administration approval to perform EKG services in addition to the procedures for which they were previously certified:

1. Almar Clinical Laboratory, 2407 West Peterson Avenue, Chicago, Illinois 60645.
2. Francisco Medical Laboratory, 9450 South Francisco Avenue, Evergreen Park, Illinois.
3. Northbrook Clinical and X-Ray Laboratory, 1775 Walters Avenue, Northbrook, Illinois
4. Parkway Laboratories, 403 East Marquette Road, Chicago, Illinois.
5. Thornburg Clinical Laboratory, 720 South Michigan Avenue, Chicago, Illinois.
6. Beverly-Sheraton Laboratories, Inc., 9449½ South Ashland Avenue, Chicago, Illinois 60620.
7. Highland Medical Laboratories, 7922 South Ashland Avenue, Chicago, Illinois.
8. Campos Laboratory, 1608 North Milwaukee, Chicago, Illinois.
9. Doctors Medical Laboratory, Inc., 11440 South Michigan Avenue, Chicago, Illinois 60628.
10. United Medical Laboratory, Inc., 8 South Michigan Avenue, Chicago, Illinois 60603.

Physician Services Defined

Physician services are defined by the Social Security Administration to be the professional services performed by a physician or physicians for a patient, including diagnosis, therapy, surgery, and consultation.

The interpretation by a physician of an actual electrocardiogram or electroencephalogram reading which has been transmitted via telephone (i.e., electronically) is a covered physician service.

A consultation is a covered service when it is a professional service furnished a patient by a second physician at the request of the attending physician. Such a consultation includes the history and examination of the patient as well as the written report. A recent revision by the SSA now stipulates that a physician's written report must become part of the patient's permanent medical record in order for the physician to be considered a consultant.

No coverage is available for telephone calls between physicians and patients (including those in which the physician provides advice or instructions) or visits for the *sole* purpose of obtaining or renewing a prescription, the need for which was previously determined so that no examination of the patient is performed.

SSA Changes In Lab Certification

The following laboratory has been certified for Medicare participation by the Social Security Administration:

Antillas Medical Laboratory
3109 West Armitage Avenue
Chicago, Illinois 60647

The Social Security Administration no longer considers the following laboratory certified for Medicare participation:

200 Clinical Laboratory
200 East 75th Street
Chicago, Illinois 60619

(This is not an advertisement)

...THE PREMARIN® STANDARD
(CONJUGATED ESTROGENS TABLETS, U.S.P.)

In the latest edition of the United States Pharmacopeia—*an "official compendium" of drug potency, quality, and purity*—there is now a clear distinction made between conjugated estrogens and other estrogens. And of the leading estrogen preparations available today, PREMARIN is the only one whose composition meets all of the U.S.P. specifications for conjugated estrogens.

We're of course gratified that the United States Pharmacopeia has included conjugated estrogens in the U.S.P. XVIII, and that PREMARIN meets the U.S.P. standard for conjugated estrogens. But, above and beyond meeting all of the U.S.P. specifications, PREMARIN continues to be manufactured with natural estrogens exclusively and contains no synthetic supplement.

For more than 28 years it has been manufactured under the strictest quality control to assure consistency in product potency, activity and stability. For more than 28 years it has been the research standard in its field. For more than 28 years it has been the most widely prescribed agent of its kind.

PREMARIN. Assurance of quality for you and your patients.

BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN® (Conjugated Estrogens Tablets, U.S.P.)
Indications: PREMARIN provides specific replacement therapy in the management of estrogen deficiency states, notably in the menopause and postmenopause.
Precautions: *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

Failure to control breakthrough bleeding or unexpected recurrence is an indication for curettage.

In the male: Continuous therapy over prolonged periods of time may produce gynecomastia, loss of libido, and testicular atrophy.
Dosage and Administration: Cyclic administration is recommended (3 weeks of daily estrogen therapy and 1 week off).

If patient has not menstruated within last two months or more, cyclic administration is started arbitrarily. If patient is menstruating, cyclic administration is started on day 5 of bleeding.

If breakthrough bleeding occurs (bleeding or spotting during estrogen therapy), increase estrogen dosage as needed to stop bleeding. In the following cycle, the dosage level which was employed for hemostasis should be used for daily administration. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free. (See Precautions.)

Menopause (natural or artificial)—PREMARIN 1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Many clinicians favor continuing cyclic estrogen replacement therapy throughout the postmenopause as a protective influence against accelerated degenerative changes at the cellular level.

Postmenopause—(If uterus is intact the patient is considered postmenopausal from one year after cessation of menstruation to end of life span.) If the presenting symptoms are those of the menopause, see above for dosage. As a protective measure against premature degenerative changes in bone and cellular metabolism (e.g. atrophic vaginitis, osteoporosis), give PREMARIN daily and cyclically. Adjust dosage to lowest effective but subbleeding level.

Estrogen Deficient Atrophic Vaginitis, Kraurosis Vulvae, and Pruritus Vulvae—1.25 mg. to 3.75 mg. daily, or more, cyclically—depending on the tissue response of the individual patient.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.). No. 865—Each *purple* tablet contains 2.5 mg. No. 866—Each *yellow* tablet contains 1.25 mg. No. 867—Each *red* tablet contains 0.625 mg. No. 868—Each *green* tablet contains 0.3 mg.

Bottles of 100 and 1,000. The 1.25 mg. potency also available in unit dose package of 100.

AYERST LABORATORIES
New York, N.Y. 10017

7149

Ayerst

PREMARIN® (Conjugated Estrogens Tablets, U.S.P.) continues as the standard for conjugated estrogen therapy

Obituaries

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Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.

For the hypertensive patient, severe symptoms may be intensified and aggravated by emotional overreaction to stress. Acutely aware of the adverse impact his emotions may have on the course of his life, the hypertensive patient's anxieties may be increased.

Adjunctive use of Libritabs may be of significant value in reducing excessive anxiety, which can induce adverse biochemical and physiological changes related to the vascular system and, by so doing, jeopardize management of the disease itself.

Libritabs (chlordiazepoxide) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is a significant component of the clinical profile.

Libritabs is especially well suited for extended use because of its wide margin of safety. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See full prescribing information.) Moreover, the antianxiety benefits of Libritabs are generally maintained without diminution of effect or need for increase in dosage. When treatment is prolonged, periodic blood counts and liver function tests are advisable.

Libritabs (chlordiazepoxide) permits flexible, individualized therapy through its three oral dosage strengths.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

To relieve excessive anxiety in hypertensive patients

adjunctive

Libritabs®

(chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets

t.i.d./q.i.d.

up to 100 mg daily for severe anxiety

ROCHE
Roche Laboratories
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Nutley, N.J. 07110

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Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

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ROCHE

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the presidents page

Let's act - - Not react

The script was an old one.

The state has a health care problem (a projected 93 million-dollar deficit in the Medicaid program for the current fiscal year) so . . .

. . . the state discusses the problem with ISMS

. . . and the state tells the public through newspapers, radio and TV, what must be done to solve the crisis!

Then we physicians react—favorably or unfavorably.

Well . . . last month we changed the script!

One of the state's proposals was for strict state controls over hospitalization utilization review committees. Direct government control over hospitalization utilization could have only one result—another donnybrook between hospitals, physicians and state government!

Clearly, the time had come for we physicians to make our own proposal to strengthen length-of-stay procedures in hospitals. It was also clear length of stay for Medicaid patients must be a medical determination.

So we made OUR proposal public—a plan to establish average lengths of stay for various illnesses *before* Medicaid patients are admitted to the hospital. Longer-than-normal hospital stays will be justified medically.

The important point is that the *medical profession* and the *hospitals* will operate the Pre-Admission Planning Program, not state inspectors from Springfield! Through our program, it is estimated the Medicaid program can benefit to the tune of $30 million a year and—more important—the quality of care given patients will not suffer.

The program has another important aspect in that it will be part of the Foundation for Medical Care program. When the IFMC was established last May, we promised it would keep physicians in the driver's seat in implementing health care delivery programs.

Our Pre-Admission Planning Program shows we meant what we said. This program has already worked in other areas of the U.S. It is now a part of the FMC program developed by physicians in New Mexico.

Let's maintain our leadership role here in Illinois!

You recently received an application to join our Illinois Foundation for Medical Care. I urge you to fill it in and mail it to our Chicago offices right now.

Let's act—not react!

L. J. Fennimore M.D.

Nixon Speech to AMA on Film

President Nixon's speech before the AMA House of Delegates is now available on film to all state and county medical societies.

Requests for the film, "A Presidential Challenge," should be directed three weeks in advance to showing to: ISMS, Division of Legislation and Public Affairs, 360 N. Michigan Avenue, Chicago 60601.

Requests will be handled on a first come, first serve basis.

Halotestin®
(fluoxymesterone, Upjohn)

Orally active androgen about 5 times as potent in anabolic and androgenic activity as methyltestosterone. Halotestin (fluoxymesterone) induces significant retention of calcium and potassium, but retention of sodium not marked. Doses below 20 mg. daily have little effect in producing creatinuria.

Indications *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.

Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.

Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.

Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.

Supplied *Tablets: 2 mg.*, scored—bottles of 100./ *5 mg.*, scored—bottles of 50./*10 mg.*, scored—bottles of 50.

For additional product information, see your Upjohn representative or consult the package circular.

Upjohn The Upjohn Company, Kalamazoo, Michigan

JA68-7627-R MED B-5-S (LQX)

Fluorides in water may prevent bone diseases

Fluorides in drinking water may prevent degenerative bone diseases common among older people, Dr. Franklin D. Yoder, director of the Illinois Department of Public Health, stated recently.

"Contrary to the belief that fluoridated water supplies are beneficial only to children, ongoing medical research shows that fluorides may also be effective in the prevention and treatment of degenerative bone diseases that are common among older people," Yoder said.

"Dental studies were conducted in 1960-61 on 896 natives of Aurora, where the fluoride content of the water supply is 1.2 per million, and a comparable group of 135 persons in Rockford, where the fluoride content of the water is only 0.1 parts per million. The age range of the people studied was from 18 to 59. One person in 24 was decay-free in the Aurora group, while only one person in 135 was decay-free in the Rockford group, for a ratio of 5.6 to one.

"Scientific evidence also shows that relatively high intakes of fluoride may be beneficial in the prevention of osteoporosis and aortic calcification. The advantages which accrue to old people consuming appropriate levels of fluoride may have as much significance as does the prevention of dental caries by optimal intake of fluoride during childhood.

"Some scientists believe that, in the later years, a higher intake of fluoride appears to be necessary to maintain normal calcification of bone. Experimental studies indicate that the principal action of fluoride on bone is a slowing of the resorptive phase of the remodeling process, with an additional promotion of calcification.

"In fact, the time may not be far distant when fluoride will be recognized as essential to health and when, in addition to adding fluoride to the water supply, it will be prescribed for older persons to prevent senile osteoporosis and frequent fractures."

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How your Account Manager approaches your investments will be determined by the objectives set in your first discussions with him. Then, after reviewing your present portfolio, he'll design an investment plan that's yours alone.

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You can exercise complete control or, if your prefer, we will assume full discretion. Either way, your records will be readily accessible and your plan will be fully and frequently reviewed with you.

For full details on how First Investment Advisory Service can mean something better for you, call Terence Lilly at The First National Bank of Chicago. Call him at (312) 732-8440.

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Something better.



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TRUST DEPARTMENT

IMJ
Illinois Medical Journal

volume 140, number 4 October, 1971

ISMS ORGANIZATION

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted; the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1958. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in book form presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1898 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. Van Dellen is the editor today.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922 he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

OFFICERS AND PLACES OF MEETING

Year	President	Secretary	Treasurer	Meeting Place
1840	John Todd	David Prince		Springfield
1850	Rudolph Rouse	Edwin G. Meek		Springfield
1850	William B. Herrick	Edwin G. Meek	Jno. Halderman	Springfield
1851	Samuel Thompson	H. Shoemaker	R. Rouse	Peoria
1852	Rudolph Rouse	E. S. Cooper	Edw. Dickenson	Jacksonville
1853	Daniel Brainerd	H. A. Johnson	A. B. Chambers	Chicago
1854	C. N. Andrews	H. A. Johnson	N. S. Davis	LaSalle
1855	N. S. Davis	E. Andrews	J. V. Z. Blaney	Bloomington
1856	H. Noble	N. S. Davis	J. V. Z. Blaney	Vandalia
1857	C. Goodbreak	H. A. Johnson	J. V. Z. Blaney	Chicago
1858	H. A. Johnson	N. S. Davis	J. W. Freer	Rockford
1859	David Prince	N. S. Davis	J. W. Freer	Decatur
1860	Wm. M. Chambers	N. S. Davis	J. W. Freer	Paris
1863	A. McFarland	N. S. Davis	J. H. Hollister	Jacksonville
1864	A. H. Luce	N. S. Davis	J. H. Hollister	Chicago
1865	J. M. Steele	N. S. Davis	J. H. Hollister	Bloomington
1866	F. F. Haller	N. S. Davis	J. H. Hollister	Decatur
1867	H. Noble	N. S. Davis	J. H. Hollister	Springfield
1868	S. T. Trowbridge	N. S. Davis	J. H. Hollister	Quincy
1869	S. T. Trowbridge	T. D. Fitch	J. H. Hollister	Chicago
1870	J. V. Z. Blaney	T. D. Fitch	J. H. Hollister	Dixon
1871	G. W. Albin	T. D. Fitch	J. H. Hollister	Peoria
1872	J. O. Hamilton	T. D. Fitch	J. H. Hollister	Rock Island
1873	D. W. Young	T. D. Fitch	J. H. Hollister	Bloomington
1874	T. F. Worrell	T. D. Fitch	J. H. Hollister	Chicago
1875	J. H. Hollister	T. D. Fitch	Wm. E. Quine	Jacksonville
1876	T. D. Washburn	N. S. Davis	J. H. Hollister	Urbana
1877	T. D. Fitch	N. S. Davis	J. H. Hollister	Chicago
1878	J. L. White	N. S. Davis	J. H. Hollister	Springfield
1879	E. P. Cook	N. S. Davis	J. H. Hollister	Lincoln
1880	Ephraim Ingalls	N. S. Davis	J. H. Hollister	Belleville
1881	G. W. Jones	S. J. Jones	J. H. Hollister	Chicago
1882	Robert Boal	S. J. Jones	J. H. Hollister	Quincy
1883	A. T. Darrah	S. J. Jones	J. H. Hollister	Peoria
1884	E. Andrews	S. J. Jones	Walter Hay	Chicago
1885	D. S. Booth	S. J. Jones	Walter Hay	Springfield
1886	Wm. A. Byrd	S. J. Jones	Walter Hay	Bloomington
1887	Wm. T. Kirk	D. W. Graham	Walter Hay	Chicago
1888	Wm. O. Ensign	D. W. Graham	Walter Hay	Rock Island
1889	C. W. Earle	D. W. Graham	T. W. McIlvaine	Jacksonville
1890	John Wright	D. W. Graham	T. W. McIlvaine	Chicago
1891	Jno. P. Mathews	D. W. Graham	Geo. N. Kreider	Springfield
1892	Charles C. Hunt	D. W. Graham	Geo. N. Kreider	Vandalia
1893	E. Fletcher Ingals	D. W. Graham	Geo. N. Kreider	Chicago
1894	Otho B. Will	J. B. Hamilton	Geo. N. Kreider	Decatur
1895	Daniel R. Brower	J. B. Hamilton	Geo. N. Kreider	Springfield
1896	D. W. Graham	J. B. Hamilton	Geo. N. Kreider	Ottawa
1897	A. C. Corr	J. B. Hamilton	Geo. N. Kreider	East St. Louis
1898	J. N. G. Carter	E. W. Weis	Geo. N. Kreider	Galesburg
1899	J. T. Pitner	E. W. Weis	Geo. N. Kreider	Cairo
1900	H. N. Moyer	E. W. Weis	Geo. N. Kreider	Springfield
1901	G. N. Kreider	E. W. Weis	E. J. Brown	Peoria
1902	J. T. McAnally	E. W. Weis	E. J. Brown	Quincy
1903	M. L. Harris	E. W. Weis	E. J. Brown	Chicago
1904	C. E. Black	E. W. Weis	E. J. Brown	Bloomington
1905	W. E. Quine	E. W. Weis	E. J. Brown	Rock Island
1906	H. C. Mitchell	E. W. Weis	E. J. Brown	Springfield
1907	J. F. Percy	E. W. Weis	E. J. Brown	Rockford
1908	W. L. Baum	E. W. Weis	E. J. Brown	Peoria
1909	J. W. Pettit	E. W. Weis	E. J. Brown	Quincy
1910	J. L. Wiggins	E. W. Weis	E. J. Brown	Danville
1911	A. C. Cotton	E. W. Weis	E. J. Brown	Aurora

Year	President	Secretary	Treasurer	Meeting Place
1912	W. K. Newcomb	E. W. Weis	E. J. Brown	Springfield
1913	L. H. A. Nickerson	E. W. Weis	A. J. Markley	Peoria
1914	Charles J. Whalen	W. H. Gilmore	A. J. Markley	Decatur
1915	A. L. Brittin	W. H. Gilmore	A. J. Markley	Springfield
1916	C. W. Lillie	W. H. Gilmore	A. J. Markley	Champaign
1917	W. L. Noble	W. H. Gilmore	A. J. Markley	Bloomington
1918	E. B. Coolley	W. H. Gilmore	A. J. Markley	Springfield
1919	E. W. Fiegenbaum	W. H. Gilmore	A. J. Markley	Peoria
1920	J. W. Van Derslice	W. H. Gilmore	A. J. Markley	Rockford
1921	W. F. Grinstead	W. H. Gilmore	A. J. Markley	Springfield
1922	Charles Humiston	W. H. Gilmore	A. J. Markley	Chicago
1923	E. P. Sloan	W. D. Chapman	A. J. Markley	Decatur
1924	E. H. Ochsner	W. D. Chapman	A. J. Markley	Springfield
1925	L. C. Taylor	H. M. Camp	A. J. Markley	Quincy
1926	J. C. Krafft	H. M. Camp	A. J. Markley	Champaign
1927	Mather Pfeiffenberger	H. M. Camp	A. J. Markley	Moline
1928	G. Henry Mundt	H. M. Camp	A. J. Markley	Chicago
1929	J. E. Tuite	H. M. Camp	A. J. Markley	Peoria
1930	F. O. Fredrickson	H. M. Camp	A. J. Markley	Joliet
1931	Wm. D. Chapman	H. M. Camp	A. J. Markley	East St. Louis
1932	R. R. Ferguson	H. M. Camp	A. J. Markley	Springfield
1933	John R. Neal	H. M. Camp	A. J. Markley	Peoria
1934	Philip H. Kreuscher	H. M. Camp	A. J. Markley	Springfield
1935	Charles D. Center* (Past President-Elect)			
1935	Charles S. Skaggs	H. M. Camp	A. J. Markley	Rockford
1936	Chas. B. Reed	H. M. Camp	A. J. Markley	Springfield
1937	Rolland L. Green	H. M. Camp	A. J. Markley	Peoria
1938	R. K. Packard	H. M. Camp	A. J. Markley	Springfield
1939	S. E. Munson	H. M. Camp	A. J. Markley	Rockford
1940	Jas. H. Hutton	H. M. Camp	A. J. Markley	Peoria
1941	J. S. Templeton	H. M. Camp	A. J. Markley	Chicago
1942	Chas. H. Phifer	H. M. Camp	H. M. Camp	Springfield
1943	E. H. Weld	H. M. Camp	H. M. Camp	Chicago
1944	G. W. Post**	H. M. Camp	H. M. Camp	Chicago
1945	E. P. Coleman	H. M. Camp	H. M. Camp	***
1946	E. P. Coleman	H. M. Camp	H. M. Camp	Chicago
1947	R. S. Berghoff	H. M. Camp	H. M. Camp	Chicago
1948	I. H. Neece	H. M. Camp	H. M. Camp	Chicago
1949	Percy E. Hopkins	H. M. Camp	H. M. Camp	Chicago
1950	Walter Stevenson	H. M. Camp	H. M. Camp	Springfield
1951	Harry M. Hedge	H. M. Camp	H. M. Camp	Chicago
1952	C. Paul White	H. M. Camp	H. M. Camp	Chicago
1953	Leo P. A. Sweeney	H. M. Camp	H. M. Camp	Chicago
1954	Willis I. Lewis	H. M. Camp	H. M. Camp	Chicago
1955	Arkell M. Vaughn	H. M. Camp	H. M. Camp	Chicago
1956	F. Garm Norbury	H. M. Camp	H. M. Camp	Chicago
1957	F. Lee Stone	H. M. Camp	H. M. Camp	Chicago
1958	Lester S. Reavley	H. M. Camp	H. M. Camp	Chicago
1959	Raleigh C. Oldfield	H. M. Camp	H. M. Camp	Chicago
1960	Joseph T. O'Neill	George F. Lull	George F. Lull	Chicago
1961	H. Close Hesseltine	Jacob E. Reisch	Jacob E. Reisch	Chicago
1962	Edwin S. Hamilton	Jacob E. Reisch	Jacob E. Reisch	Chicago
1963	George F. Lull	Jacob E. Reisch	Jacob E. Reisch	Chicago
1964	Harlan English	Jacob E. Reisch	Jacob E. Reisch	Chicago
1965	Edward A. Piszczek	Jacob E. Reisch	Jacob E. Reisch	Chicago
1966	Burtis E. Montgomery	Jacob E. Reisch	Jacob E. Reisch	Chicago
1967	Caesar Portes	Jacob E. Reisch	Jacob E. Reisch	Chicago
1968	Newton DuPuy	Jacob E. Reisch	Jacob E. Reisch	Chicago
1969	Philip G. Thomsen	Jacob E. Reisch	Jacob E. Reisch	Chicago
1970	Edward W. Cannady	Jacob E. Reisch	Jacob E. Reisch	Chicago
1971	J. Ernest Breed	Jacob E. Reisch	Jacob E. Reisch	Chicago
1972	L. T. Fruin	Jacob E. Reisch	Jacob E. Reisch	Chicago

*Died before induction into office
**Died in office. Term completed by Robert S. Berghoff, First Vice President
***Meeting cancelled 1945

Principles Of Medical Ethics

PREAMBLE: These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8—A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Constitution And Bylaws
May 1971

Adopted, 1903
As Amended, 1971

CONSTITUTION

ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

ARTICLE VI. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

ARTICLE VII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates and general scientific meetings which shall be open to all registered members.

ARTICLE VIII. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, nineteen trustees and one trustee at large, and such other officers as the Bylaws may provide.

ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual business meeting of the House of Delegates provided that the amendment shall have been proposed at the preceding annual business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. *Members.*

A. *Active Members.* The active members of this Society shall consist of regular members, emeritus members, retired members, provisional members, intern members and residency members. Active members shall enjoy full privileges which include membership in the American Medical Association.

B. *Special Members.* The special members of this Society shall be distinguished because of their contributions to the science and art of medicine.

(1) *Distinguished Members.* Distinguished members shall be:

a. Physicians of Illinois or other states, or foreign countries who have risen to prominence in the profession; or

b. Teachers of medicine or of the sciences allied to medicine, not eligible for active membership; or
c. Members of associated arts or sciences who have made significant contributions to medicine.

(2) *Election.* Special members may be nominated by any member of the House of Delegates, and may be elected by the House at any annual convention by a two-thirds vote.

(3) *Privileges.* Special members shall not be entitled to hold office nor to vote, and shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other Society activities.

Section 2. *Qualifications for Membership.*

A. Every physician duly licensed and registered in the State of Illinois to practice medicine in all its branches who is a resident of the State of Illinois, a citizen of the United States, who is of good moral character and professional standing, and a member of his component medical society, shall be eligible for regular membership.

B. Provisional membership shall be available to any Illinois physician who has made a declaration of intention to become a citizen of the United States, who has received a license in this State to practice medicine in all of its branches, and who—with the exception of United States citizenship—possesses all of the qualifications for membership prescribed by these Bylaws. Provisional membership shall terminate one year after the expiration of the minimum period of time within which such member could have perfected his citizenship. After obtaining full citizenship and prior to the expiration of his provisional membership, such member may be, upon application to his component medical society, transferred to regular membership.

C. The following shall also be eligible if approved and recommended by the component medical society:

(1) Every physician serving as a full time employee at the headquarters of the American Medical Association;

(2) Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively full-time in their respective service, and thereafter, if they have been retired on account of age or physical disability, or after long and honorable service under the provision of an Act of Congress;

D. Physicians otherwise eligible for membership, and licensed in one of the States of the Union, but not licensed in Illinois, and who are not engaged in the active practice of medicine, but otherwise employed in an allied medical activity which does not require licensure, shall be eligible for membership if approved and recommended by the component medical society and approved by the Board of Trustees.

Section 3. *Emeritus Members.* A member to be elected to emeritus membership shall:

currently be in good standing, have been a member in good standing for 35 years, have reached, or will have reached before the next fiscal year, the age of 70 years, and have made written application to and have been recommended by his component society for emeritus status.

Such membership shall become effective January 1 of the year following election. Emeritus members shall have all the rights and privileges of membership without the payment of dues to the component or state society.

Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of this Society for at least five years.

Section 4. *Retired Members.* A member who has been in good standing but who by reason of age or incapacity, has retired from active practice, may upon application to and upon recommendation of his component society, be made a retired member, without payment of dues to the component or state society.

Section 5. *Intern Members.* Any person who is a graduate of a medical school, who is of good moral character and professional standing and serving an internship in any hospital in the State of Illinois approved by the American Medical Association, is eligible for intern membership upon the recommendation of any two members of this Society who are also members of his hospital staff.

The physician's intern membership shall cease at the end of the year in which his internship training terminates, and if he wishes to become a member of this Society, he must apply for a residency or regular membership through his component society.

Dues for intern membership shall be minimal.

Section 6. *Residency Members.* After being licensed to practice medicine, a physician serving full time as a resident in a residency approved by the American Medical Association, is eligible for full membership.

Dues for residency members shall be minimal.

A residency member must be a graduate of a medical school, have a degree of Doctor of Medicine or its equivalent, and must be a member in good standing of his component society.

The physician's residency membership shall cease at the end of the year in which his residency training terminates, and if he wishes to become a member of this Society, he must apply for regular membership through his component society.

Section 7. *Tenure of Membership.* The name of a physician on the properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this Society, and afford all the rights and privileges pertaining thereto.

Section 8. *Withdrawal of Privileges.* No person who is under sentence of suspension or expulsion from a component society, shall be entitled to any of the rights or benefits of this Society, nor shall he be permitted to take part in any of the proceedings until he has been reinstated.

Section 9. *Student Committee Membership.* Students nominated by Illinois Chapters of the Student American Medical Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees, to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with permission of the House of Delegates) the right to speak on the floor of the House, but shall have no vote out of committee. They shall pay no dues.

CHAPTER II. ANNUAL CONVENTIONS

Section 1. *Date.* The Board of Trustees shall determine the date for the annual convention.

Section 2. *Meeting Place.* The meeting place for the annual convention shall be determined by the House of Delegates from a list of cities extending invitations, subject to investigation of the facilities and recommendation by the Board of Trustees.

Section 3. *Scientific Meetings.*

A. With the consent of the House of Delegates or the Board of Trustees any special group may conduct its meeting in connection with the annual convention of this Society.

B. All registered members may attend and participate in the proceedings and discussions of the general scientific meetings and of the section meetings.

C. The general scientific meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and to the public.

D. All papers read before the Society or any section thereof, shall become the property of the Society. Each paper shall be deposited with the secretary when read, and presentation of a paper to the Illinois State Medical Society shall be considered tantamount to the assurance on the part of the writer that such paper has not already been published.

E. The Board of Trustees shall be entirely responsible for the annual convention.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of:

A. Delegates elected by the component societies
B. The president
C. The president-elect
D. The secretary-treasurer
E. The speaker of the House (or the vice speaker when presiding) and
F. The trustees.

Non-voting members shall be the vice presidents, the vice speaker (when not presiding), the past trustees, past speakers, past presidents, general officers of the AMA and delegates from the Illinois State Medical Society to the AMA.

Section 2. *Meetings.* The House of Delegates shall meet at the time and place of the annual convention of the Society, and shall fix its hours of meeting so that they shall not conflict with the general scientific meetings of the Socicty. If the interests of the Society and the profession require, the House of Delegates may meet in advance of the general scientific meetings.

Section 3. *Quorum.* Fifty delegates representing not less than twenty component societies shall constitute a quorum for the transaction of business.

Section 4. *Special Meetings.* Special meetings of the House of Delegates may be called by the president or a majority of the Board of Trustees, or shall be called on petition of twenty component societies.

When a special meeting is thus called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 5. *Delegates.*

A. Component Societies. Each component society shall be entitled to send to the House of Delegates each year, one delegate for each 75 members, and one for a major fraction thereof; but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws, shall be entitled to one delegate.

The number of delegates to which any component society is entitled shall be determined by the number of active members of the component

society on the membership rolls of the Illinois State Medical Society as of December 31 of the preceding year.

The term of office of a delegate shall begin January 1 following his election, and shall be for two years, or until his successor has been elected. Component societies with one delegate only, may elect for one year.

B. Affiliated Groups. The combined Illinois chapters of the Student American Medical Association shall be considered a single affiliate group.

1. *Representation.* The Student American Medical Association, as an affiliate group, shall be entitled to one delegate and one alternate delegate to serve in the House of Delegates with vote.
2. *Term of office.* The term of office of a delegate shall begin January 1, following his election, and shall be for two years, or until his successor has been elected.

Section 6. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the president and/or the secretary of the component society, stating that the delegate or alternate has been regularly elected to the House of Delegates.

A delegate or his alternate may be seated without credentials, provided he is properly identified and so certified to the secretary of the Illinois State Medical Society.

Whenever a delegate or his alternate are both unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate.

A delegate whose credentials have been accepted by the Reference Committee on Credentials and whos name has been placed on the roll of the House, shall remain a delegate until final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by that Committee. After the alternate has been seated, he cannot be replaced for that session.

Section 7. *AMA Delegates and Alternate Delegates.* The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 8. *District Divisions.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

CHAPTER IV. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, nineteen trustees and one trustee-at-large.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice-president, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years.

The speaker and vice speaker shall not be elected for more than three consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become a trustee-at-large for a term of one year.

CHAPTER V. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

Section 2. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the president shall fill the office by appointment.

Section 3. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 4. *The Speaker.* The speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of delegates.

He shall seek the advice of officers and trustees.

He shall be an ex-officio member of the Committee on Constitution and Bylaws.

Section 5. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence or at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 6. *The Secretary-Treasurer.* In addition

to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom, owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

CHAPTER VI. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of nineteen trustees elected by the House of Delegates [nine shall be chosen from district number three, and one from each of the other ten districts (see map attached), these districts of the geographical area as of May, 1946], and one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and secretary-treasurer.

The vice presidents and vice speakers shall attend the meetings (including executive sessions), with the right of discussion, but without the right to vote.

Section 2. The duties of the Board of Trustees are executive, custodial and judicial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before the House of Delegates or the general scientific meetings, shall be referred to the Board of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board shall also employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

Section 6. *Quorum.* Ten members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publications.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member all district committees. He shall report to the Board of Trustees the actions of the component societies on reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report shall also specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society, those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER VIII. DUES AND EXPENSES

Section 1. *Annual Dues.* Assessments may be

levied by the House of Delegates on each component society on a proportional basis. The amount of the dues shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association.

These annual dues shall include the annual subscription to the Illinois Medical Journal which shall be at least fifty per cent of the regular subscription price of the Journal.

Section 2. The Board of Trustees upon recommendation of the component society, shall give 50% reduction in dues to teaching, research and administrative personnel in full time employment in the approved medical schools in Illinois, or similar not-for-profit institutions in Illinois.

Section 3. Physicians in private practice of medicine may be given a 50% reduction in dues during the first year of practice upon recommendation of their component society.

Section 4. Physicians approved for membership after June 30 shall pay one-half of the annual dues for that year.

Section 5. The Board of Trustees may authorize the remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association.

CHAPTER IX. COMMITTEES

Part 1. COUNCILS AND COMMITTEES

Section 1. *Councils and Committees*

The councils and committees of the Illinois State Medical Society shall be:

A. Councils (Standing committees)

B. Reference committees of the House of Delegates

C. Board of Trustees committees

Section 2. The appointing authority may alter council and/or committee membership and assign or delete duties as it deems necessary.

Part 2. COUNCILS

Section 1. The Councils of the Society shall be:

A. Medical-Legal Council

B. Council on Governmental Affairs

C. Council on Education and Manpower

D. Council on Economics and Peer Review

E. Council on Environmental and Community Health

F. Council on Public Relations and Membership Services

G. Council on Mental Health and Addiction

H. Council on Social and Medical Services; and such other Councils as may be established from time to time by the Board of Trustees.

Section 2. *Organization of Councils.*

A. Councils shall be appointed by the Board of Trustees.

B. The chairman of a Council shall be designated by the Board. He may not serve as chairman of any committee of the Council.

C. Each Council shall have authority to request the Board of Trustees to appoint sub-committees for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of the sub-committee.

D. Only active members of the Illinois State Medical Society (who are not voting members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Voting members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

E. Each Council, sub-committee or special committee shall have authority to make rules to govern its procedures subject to:

(1) Specific requirements of the Constitution and Bylaws and the policies of the House of Delegates, and

(2) Approval of the Board of Trustees.

F. Each Council shall submit for adoption, a budget for the ensuing year, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

G. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.

H. Each Council shall have members in sufficient quantity so that each sub-committee may be chaired by a different member.

I. Terms of office of members of the Councils shall not be more than three years, but may be terminated at any time at the discretion of the Board. No member of a Council shall serve more than three consecutive terms. Service of two or more years in an unexpired term shall be considered a full term.

J. *Reports.*

(1) Special committee reports shall be

made by the chairman to the sub-committee from which he was appointed.

(2) Reports from sub-committees (which shall contain summaries of the report of special committees) shall be made by the chairman to the Council of which he is a member.

(3) Reports of Council activities shall include recommendations on reports and requests from sub-committees, and shall be made to the Board of Trustees by the chairman of the Council.

(4) The Chairman of the Council with the approval of the Board, may permit any member of a committee under the Council to clarify the report of that committee to the Board.

(5) The Chairman of any committee may request the Board of Trustees to allow him, or any member of his committee, to appear before the Board.

(6) All councils shall submit to the House of Delegates, written reports summarizing all actions, and may include recommendations for House consideration.

K. Vacancies on any committee may be filled at any time by the Board of Trustees. Committee membership may be enlarged or decreased or the committee may be discharged by the Board of Trustees.

L. *Committee Meetings*

The chairman of a committee, when he considers it expedient and with the consent of two thirds of the members of the committee, may conduct business or hold meetings by mail or by conference call, provided all members of the committee are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all committee members.

Section 3. *Duties (Area of Concern)*

A. The Medical-Legal Council shall be concerned in the areas of:
1. Liaison with the Illinois Bar Association
2. Liaison with courts, particularly where improper medical testimony is involved
3. Implementation of the Impartial Medical Testimony Rule
4. Legal aspects of medical practice other than in the area of mental health
5. Licensing and standards of practice
6. Quackery
7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in areas of:
1. Federal and state legislation—analysis and communication
2. Legislative liaison—both state and federal
3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:
1. Liaison with medical schools, curricula, etc.
2. Health manpower and training
3. Postgraduate education
4. Internships, residencies, etc.
5. Scientific assembly
6. Student loans
7. Liaison with Student American Medical Association
8. Continuing Medical Education

D. The Council on Economics and Peer Review shall be concerned in the areas of:
1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)
2. Relations with prepayment, insurance and other third party plans
3. Fees and fee adjudication as promulgated by the Usual and Customary Fee Committee
4. Health care cost and utilization
5. Peer Review

E. Council on Environmental and Community Health shall be concerned in the areas of:
1. Governmental administrative regulation —Departments of Health
2. Public Safety
3. Occupational Health
4. Child and School Health
5. Pollution
6. Nutrition

F. Council on Public Relations and Membership Services shall be concerned in the areas of:
1. Publicity and promotion
2. Media relations
3. Exhibits and public service programming
4. Religion and medicine
5. Illinois State Medical Society sponsored membership insurance programs
6. New member orientation and membership benefit explanation
7. Fifty Year Club

G. Council on Mental Health and Addiction shall be concerned in the areas of:
1. Facilities and services
2. Liaison with Department of Mental Health
3. Legal aspects of commitment, etc.
4. Narcotics and dangerous drugs
5. Alcoholism

H. Council on Social and Medical Services shall be concerned in the areas of:
1. Health care facilities and services
2. Emergency and disaster care
3. Liaison with other health professional and health oriented organizations
4. Relations with specialists not otherwise assigned
5. Problems of aging
6. Rural Health

PART 3. HOUSE OF DELEGATES COMMITTEES.
SECTION I. *Committees*

A. *Appointment.* Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. *Duties of Reference Committees.* References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. *Organization.* Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

D. *Reference Committees.* The following committees are hereby provided for:
A Committee on Credentials
A Committee on Rules and Order of Business
Tellers and Sergeants-at-Arms
A Committee on Changes in the Constitution and Bylaws
and such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economics activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

E. *The Committee on Credentials* shall consider all questions regarding the registration and the credentials of the delegates. It shall pass out and receive the attendance slips for each session of the House of Delegates, and perform any other duties assigned.

F. *A Committee on Rules and Order of Business* shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

G. *The Tellers and Sergeants-at-Arms* shall
1. Serve the speaker of the House of Delegates
2. Distribute, collect and tally votes when a ballot is taken, or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

H. *The Committee on Changes in Constitution and Bylaws* shall consider all proposed amendments to the Constitution and Bylaws.

The chairman of the Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

Section I. *Ad hoc Committees*

1. Ad hoc committees shall be appointed by the speaker of the House of Delegates to accomplish specific duties.
2. Any member of the Society may be asked to serve.
3. The terms of appointment shall be for the duration of the task, or until the committee shall be discharged.
4. Ad hoc committees expected to serve for more than one year, shall be reorganized and given the status of a sub-committee or special committee under the appropriate Council and should be appointed by the Board of Trustees.
5. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees keeping it informed of all current activities.

PART 4. *Committees*

Section 1. Board of Trustees Committees.

The Board shall form the following committees within itself:
A. Executive Committee
B. Finance Committee
C. Policy Committee
D. Ethical Relations Committee
E. Committee on Committees
F. Committee on Constitution and Bylaws

G. Committee on Publications
H. Advisory Committee to the Woman's Auxiliary, and

such others as deemed necessary.

Section 2. *Duties of the Committees.*

A. *Executive Committee.* The Executive Committee shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board, provided he is still a Trustee.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. *Finance Committee.* The Finance Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Medical Benevolence Committee shall be a subcommittee of the Finance Committee. It shall:

1. Examine applications to the Society for assistance to determine eligibility for assistance.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Recommend to the Finance Committee the allotment for each recipient, and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. *Policy Committee.* The Policy Committee of the House of Delegates to determine the shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. *The Ethical Relations Committee.* The Ethical Relations Committee shall be constituted and function as stipulated in CHAPTER XI. DISCIPLINE. Part 2 Illinois State Medical Society procedures.

E. *The Committee on Committees.* The Committee on Committees shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board. The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

F. *The Committee on Constitution and Bylaws.* The Committee on Constitution and Bylaws shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

G. *The Committee on Publications.* The Committee on Publications shall be composed of members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal.*

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the Journal. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal.*

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

H. *Advisory Committee to the Woman's Auxiliary.* The Advisory Committee to the

Woman's Auxiliary shall consist of the president elect as chairman, the president and the chairman of the Board of Trustees.

The Committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this Society before the first Wednesday of January each year.

Section 10. Any component society which fails to pay its assessment or make the annual report required on or before March fifteenth shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

A member is in good standing unless otherwise disqualified, whose dues are paid on or before the first day of March of the current year. Immediately after the first of March, each delinquent member shall be notified that in consequence of nonpayment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be dropped automatically. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition, make application as a new member.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon the members of the component societies.

CHAPTER XI. DISCIPLINE

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Ethical Relations Committee.* Each component society may have, either by appointment or election, an Ethical Relations Committee, whose duty it shall be to prosecute formal charges of unethical conduct. In the event that the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

All parties may have legal counsel present to advise and counsel them during the proceedings, but such counsel may not participate in the proceedings, and may be excluded from the hearing by the chairman or by vote of the committee.

The component society Ethical Relations Committee may establish reasonable rules of procedure, and they shall not be bound by the technical rules of evidence as the same pertain in courts of law. In all proceedings before such Ethical Relations Committees, the complainant, the accused and all witnesses before the committee shall be placed under oath.

The Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 2. *Offenses.* Any member of a component society shall be subject to censure, suspension or expulsion by such component society when

A. He has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or

B. He has been adjudged guilty by his component society in accordance with the procedural requirement of these bylaws:

(1) of a gross misconduct as a physician, or

(2) of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Charges Initially Presented to the Illinois State Medical Society.* Original complaints received by the Illinois State Medical Society shall be referred directly to the secretary of the component society of which the accused is a member or to the district Ethical Relations Committee.

Section 4. *Principles of Justice.* The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

A. An accused is presumed to be innocent until he has been proven guilty.

B. Formal charges before the Ethical Relations Committee of the component society or district Ethical Relations Committee must be presented under oath by the complaining party.

C. A trial shall be held by the committee within 30 days after the formal charges have been filed, unless continued by the chairman of the committee upon good cause shown.

D. The individual against whom formal charges have been filed shall be sent a copy of said charges by certified mail at least 10 days before the date set for the trial, together with a statement of the rights of the accused as follows:

(1) to be represented by any member of the society as counsel and that he may have legal counsel present;

(2) to cross-examine witnesses;

(3) to offer in evidence any pertinent records or documents;

(4) to object to any testimony or exhibits offered in evidence;

(5) to address the trial body in his own behalf;

(6) to be tried only on the specific charges filed;

(7) to have stricken from the record any improper testimony or exhibits;

(8) to appeal to the Board of Trustees of the Illinois State Medical Society.

Section 5. *Records.* A comprehensive stenographic record of the proceedings, together with all exhibits, must be kept for reference, and shall be available until final adjudication has been made.

In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record shall be forwarded by certified mail to the Board of Trustees of the ISMS at least ten days prior to the date the appeal is to be heard.

If the component society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused not guilty.

Section 6. *Verdict.* The committee, sitting as a trial body, shall find the accused either guilty or not guilty. If the verdict is guilty, the trial body shall recommend censure, suspension or expulsion.

The findings of the trial body must be presented to the component county society for approval or rejection. The accused must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the trial body are against the accused the secretary of the component society shall acquaint the accused, by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. *Illinois State Medical Society Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

Section 2. *Appeals from Component Society Verdicts.* Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must be accompanied by a comprehensive stenographic record of the proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused "not guilty"). The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. *Verdict.* The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial, the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. *Notification and right of appeal.* The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

CHAPTER XII PEER REVIEW ILLINOIS STATE MEDICAL

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Peer Review Committee.* Each component Society shall have, either by appointment or election, a Peer Review Committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients, institutions, insurance carriers, or government agencies.

The district peer review committee shall function and operate on behalf of any county society which does not establish such a committee.

Section 2. The committee shall consist of a chairman and such members representing both general practice and various specialties as each individual county society shall determine. Such committee should have access to counsel from each of the various medical specialties. The component county society may establish reasonable rules of procedure but shall not be bound by the technical rules of evidence as the same pertains in courts of law. All proper complaints shall be reduced to writing and shall be signed by the individual making the complaint.

Section 3. Original complaints received by the Illinois State Medical Society shall be referred to the proper county society or to the district committee.

Section 4. The Peer Review Committee shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 5. The Peer Review Committee shall initiate consideration of all complaints and matters filed with it within 60 days from the date of filing and shall render an opinion within 30 days after the conclusion of the hearing. In the event the committee does not follow this procedure any party may appeal for relief to the proper district committee whose procedure shall be the same as is set forth herein for county societies.

Section 6. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings in writing to all parties involved. In the event the investigation and study of the committee results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society; or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing to the component society.

Section 7. In its study and deliberations the Peer Review Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 8. Any party to the proceedings considering himself aggrieved by the findings and recommendations of the committee shall have the right to appeal through the component society to the Illinois State Medical Society.

Section 9. In the event of an appeal to the Illinois State Medical Society, the county society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the opinions of the county or district committee. Any appeal hereunder shall be filed with Illinois State Medical Society within 30 days after the final opinion of the county or district committee has been rendered.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. All appeals received by the Illinois State Medical Society shall be referred to the Council on Economics and Peer Review of the Board of Trustees, which shall review opinions of the county or district peer review committee. The Council shall have the power to counsel with and obtain information from medical specialists when appropriate.

Section 2. The Council upon receiving notice of an appeal shall set the matter for hearing within 30 days after the appeal has been filed and at such hearing shall review the record sent to it from the county society or district society, receive additional pertinent evidence any interested party desires to offer and render its conclusions and findings in writing, copies of which shall be mailed to all interested parties. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings to all parties involved. The conclusions and findings shall be advisory only.

Section 3. The Council on Economics and Peer Review of the Illinois State Medical Society shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 4. In the event the investigation and study of the Council results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing back to the component society.

CHAPTER XIII. MISCELLANEOUS

Section 1. The fiscal year of this Society shall be from January 1 to December 31 inclusive.

Section 2. Robert's "Rules of Order, Revised," shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

Order of Business of the House of Delegates

FIRST SESSION

1. Call to order.
2. Report of Committee on Credentials.
3. Roll Call.
4. Reading and approval of minutes of last meeting.
5. Appointment of Reference Committees.
6. Reports of Officers.
7. Reports of the Trustees, the Editor, etc.
8. Reports of Standing Committees.
9. Reports of Board Committees.
10. Reports of Special Committees.
11. Reading of Resolutions.
12. Unfinished Business.
13. New Business.
14. Recess.

LAST SESSION

1. Call to order
2. Report of Committee on Credentials
3. Roll Call
4. Reports of Reference Committees
5. Fixing of per capita tax for ensuing year
6. Selection of meeting place for next annual meeting. (Subject to the investigations of the Board.)
7. Unfinished business
8. Election of
 (a) officers
 (b) trustees
 (c) delegates to the AMA
 (d) alternate delegates to the AMA
9. Induction of President Elect into the office of President
10. New business
11. Adjournment (sine die)

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ISMS House of Delegates

OFFICIAL MEMBERS OF THE HOUSE WITH THE RIGHT TO VOTE

Officers of ISMS

President—L. T. Fruin
5 Citizen's Square, Normal 61761
President-elect, Frank J. Jirka, Jr.
1507 Keystone, River Forest 60305
Secretary-Treasurer, Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
Speaker of the House, Paul W. Sunderland
214 N. Sangamon St., Gibson City 60936

Board of Trustees

1st District—Joseph L. Bordenave 1974
1665 South St., Geneva 60134
2nd District—Allan L. Goslin 1974
712 N. Bloomington, Streator 61364
3rd District—David S. Fox 1973
20829 Green Center Court,
Olympia Fields 60461
Robert T. Fox 1973
2136 Robin Crest Lane, Glenview 60025
Eugene T. Hoban 1972
6429 North Ave., Oak Park 60302
Frederic D. Lake 1972
1041 Michigan Ave., Evanston 60202
William M. Lees 1974
6518 N. Nokomis, Lincolnwood 60646
George C. Shropshear 1974
1525 E. 53rd, Chicago 60615
Philip G. Thomsen 1974
13826 Lincoln, Dolton 60419
Frederick E. Weiss 1973
15643 Lincoln, Harvey 60426
Warren W. Young 1972
10816 Parnell Ave., Chicago 60628
4th District—Fred Z. White 1973
723 N. 2nd St., Chillicothe 61523
5th District—A. Edward Livingston 1973
219 N. Main, Bloomington 61701
6th District—Mather Pfeiffenberger 1972
State & Wall Streets, Alton 62002
7th District—Arthur F. Goodyear 1973
142 E. Prairie Ave., Decatur 62523
8th District—Eugene P. Johnson 1973
P.O. Box 68, Casey, 62420
9th District—Charles K. Wells 1972
117 N. 10th Street, Mt. Vernon 62864
10th District—Willard C. Scrivner 1972
6600 West Main St., Belleville, 62223
11th District—Joseph R. O'Donnell 1974
444 Park, Glen Ellyn 60137
Trustee-at-Large, J. Ernest Breed 1972
55 E. Washington St., Chicago 60602

Representatives of County Societies

A complete listing of delegates and alternates to the ISMS House will appear with the convention program.

EX-OFFICIO MEMBERS OF THE HOUSE WITHOUT THE RIGHT TO VOTE

Past Presidents

J. Ernest Breed 1971
Everett P. Coleman 1945-1946
Edward W. Cannady 1970
Newton DuPuy 1968
Harlan English 1964
Edwin S. Hamilton 1962
H. Close Hesseltine 1961
James H. Hutton 1940
Willis I. Lewis 1954
George F. Lull 1963
Burtis E. Montgomery 1966
Edward A. Piszczek 1965
Caesar Portes 1967
Leo P. A. Sweeney 1953
Philip G. Thomsen 1969
Arkell M. Vaughn 1955

Past Trustees

William E. Adams
Chicago, Trustee of the 3rd District
Earl H. Blair
Chicago, Trustee of the 3rd District
Walter C. Bornemeier
Chicago, Trustee of the 3rd District
Carl E. Clark
Sycamore, Trustee of the 1st District
Willard W. Fullerton
Sparta, Trustee of the 10th District
George E. Griffin
Princeton, Trustee of the 2nd District
Lee N. Hamm
Lincoln, Trustee of the 5th District
James B. Hartney
Oak Park, Trustee of the 3rd District
George A. Hellmuth
Chicago, Trustee of the 3rd District
Bernard Klein
Joliet, Trustee of the 11th District
Ted LeBoy
Chicago, Trustee of the 3rd District
William A. McNichols, Jr.
Dixon, Trustee of the 2nd District
Warner H. Newcomb
Jacksonville, Trustee of the 6th District
Ralph N. Redmond
Peoria, Trustee from the 4th District
Paul P. Youngberg
Moline, Trustee of the 4th District
Darrell H. Trumpe
Springfield, Trustee of the 5th District
William H. Schowengerdt
Champaign, Trustee of the 8th District

Past Speakers

Walter C. Bornemeier, Chicago 1961-1964
Edward W. Cannady, Belleville 1964-1967
Maurice M. Hoeltgen, Chicago 1967-1970

Vice-Presidents of the ISMS

C. J. Jannings III, First Vice-President
William E. Adams, Second Vice-President

Vice-Speakers of the ISMS House of Delegates

Andrew J. Brislen
(Except when presiding as Speaker)

AMA DELEGATION

Delegates to the American Medical Association

Elected May 21, 1969
(to serve from Jan. 1, 1970 to Dec. 31, 1971)

EDWARD W. CANNADY
4601 State Street, East St. Louis 62205

HARLAN ENGLISH
909 North Logan Avenue, Danville 61833

THEODORE GREVAS
1800 Third Avenue, Rock Island 61201

EDWARD A. PISZCZEK
6410 North Leona, Chicago 60646

HAROLD A. SOFIELD
715 Lake Street, Oak Park 60301

PHILIP G. THOMSEN
13826 Lincoln, Dolton 60419

Elected May 20, 1970
(to serve from Jan. 1, 1971 to Dec. 31, 1972)

CARL E. CLARK
225 Edward Street, Sycamore 60178

H. CLOSE HESSELTINE
5807 South Dorchester, Chicago 60637

MAURICE M. HOELTGEN
1836 West 87th Street, Chicago 60620

JOSEPH R. MALLORY
Linck Clinic, Mattoon 61938

FRANCIS W. YOUNG
9933 South Western Avenue, Chicago

Elected May 19, 1971
(to serve from Jan. 1, 1972 to Dec. 1, 1973)

JACK GIBBS
175 South Main Street, Canton 61520

THEODORE GREVAS
1800 Third Avenue, Rock Island 61201

MORGAN MEYER
573 South Lombard, Lombard 60148

EDWARD A. PISZCZEK
6410 North Leona, Chicago 60646

HAROLD A. SOFIELD
715 Lake Street, Oak Park 60301

PHILIP G. THOMSEN
13826 Lincoln, Dolton 60419

★ ★ ★

Honorary Delegates

WALTER C. BORNEMEIER
4665 Peterson Avenue, Chicago 60646

EDWIN S. HAMILTON
985 Cobb Street, Kankakee 60901

GEORGE F. LULL
2440 Lakeview Avenue, Chicago 60614

BURTIS E. MONTGOMERY
37 South Main Street, Harrisburg 62946

Alternate Delegates to the American Medical Association

Elected May 21, 1969
(to serve from Jan. 1, 1970 to Dec. 31, 1971)

HERSCHEL BROWNS
4600 North Ravenswood Avenue, Chicago 60640

WILLIAM LEES
6518 North Nokomis, Lincolnwood 60646

MORGAN MEYER
573 South Lombard, Lombard 60148

GLEN TOMLINSON
301 Walnut Street, Lincoln 62650

GEORGE TURNER
6627 Ponchartrain Avenue, Chicago 60646

*CHARLES K. WELLS
117 North 10th Street, Mt. Vernon 62864

**to fill unexpired term of Boyd McCracken*

Elected May 20, 1970
(to serve from Jan. 1, 1971 to Dec. 31, 1972)

**JACK GIBBS
175 South Main Street, Canton 61520

FRANK J. JIRKA, JR.
1507 Keystone Avenue, River Forest 60305

JOSEPH R. O'DONNELL
444 Park, Glen Ellyn 60137

FRED A. TWOROGER
4753 Broadway, Chicago 60640

THEODORE R. VAN DELLEN
435 North Michigan Avenue, Chicago 60611

***John Ring, 511 East Hawley Street, Mundelein 60060, elected to fill term of JACK GIBBS from Jan. 1, 1972 to Dec. 31, 1972.*

Elected May 19, 1971
(to serve from Jan. 1, 1972 to Dec. 31, 1973)

HERSCHEL BROWNS
4600 North Ravensood Avenue, Chicago 60640

WILLIAM LEES
6518 North Nokomis, Lincolnwood 60646

GEORGE C. SHROPSHEAR
1525 East 53rd Street, Chicago 60615

PAUL SUNDERLAND
214 North Sangamon, Gibson City 60936

GLEN TOMLINSON
301 Walnut Street, Lincoln 62650

CHARLES K. WELLS
117 North 10th Street, Mt. Vernon 62864

Officers of County Medical Societies 1971

County Name	President	Secretary
Adams Members: 78-Dist. No. 6	L. C. Hollister, Jr. 1114 Broadway, Quincy, 62301	Julio delCastillo Illinois Bank Bldg., Quincy, 62301
Alexander Members: 7-Dist. No. 10	Paul Spence 800½ Commercial, Cairo, 62914	Charles L. Yarbrough 800½ Commercial Ave., Cairo, 62914
Bond Members: 6-Dist. No. 7	Charles R. Daisy 308 W. College Avenue, Greenville, 62246	James Goggin 207 North Second, Greenville, 62246
Boone Members: 17-Dist. No. 1	John Steinkamp 824 Van Buren, Belvidere, 61108	Earl S. Davis 119 South State, Belvidere, 61108
Bureau Members: 26-Dist. No. 2	Louis D. Tarsinos 682 E. Peru, Princeton, 61356	Karl D. Nelson 101 Park Avenue, Princeton, 61356
Carroll Members: 8-Dist. No. 1	L. B. Hussey P.O. Box 310, Savanna, 61074	E. P. Mitchell Shannon, 61078
Cass Members: 8-Dist. No. 6	R. A. Spencer 115 West 4th Street, Beardstown, 62618	A. G. Hyde 507 Washington St., Beardstown, 62618
Champaign Members: 187-Dist. No. 8	Herbert Friedman Carle Clinic, Urbana, 61801	Paul W. Yardy 1109 S. Lincoln Ave., Urbana, 61801
Christian Members: 16-Dist. No. 7	P. K. Hagen 311 S. Main Street, Taylorville, 62568	J. W. Murphy 301 S. Webster St., Taylorville, 62568
Clark Members: 5-Dist. No. 8	Eugene P. Johnson P.O. Box 68, Casey, 62420	Charles C. Moore, Jr. Martinsville Clinic, Martinsville, 62442
Clay Members: 5-Dist. No. 7	A. Paul Naney Flora Clinic, Flora, 62839	Donald L. Bunnell Flora Clinic, Flora, 62839
Clinton Members: 12-Dist. No. 7	J. R. Sosa 204 Munster Street, Germantown, 62245	F. H. Ketterer 289 N. Main St., Breese, 62230
Coles-Cumberland Members: 35-Dist. No. 8	G. D. Wright 1517 University Drive, Charleston, 61920	Jerry D. Heath Health Service, Eastern Ill. Univ., Charleston, 61920
Crawford Members: 13-Dist. No. 8	H. F. Iknaya 408 S. Cross, Robinson, 62454	W. B. Schmidt 408 S. Cross, Robinson, 62454
De Kalb Members: 53-Dist. No. 1	Gordon Graham 901 N. First St., DeKalb, 60115	Frank Luedtke DeKalb Clinic, DeKalb, 60115
De Witt Members: 9-Dist. No. 5	John W. Veirs 219 East Main St., Clinton, 61727	Charles Ramey 215 East Main St., Clinton, 61727
Douglas Members: 11-Dist. No. 8	Grant A. Jones 318 South Ash Street, Arthur, 61911	Elmer S. Allen 120 S. Locust St., Arcola, 61910
Du Page Members: 395-Dist. No. 11 Lillian Widmer, Exec Sec. 646 Roosevelt Rd, Glen Ellyn, 60137	Dan P. Butcher 135 S. Kenilworth, Elmhurst, 60126	James P. Campbell 322 N. Blanchard St., Wheaton, 60187
Edgar Members: 15-Dist. No. 8	Gordon H. Sprague 502 Shaw Avenue, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris, 61944
Edwards Members: 2-Dist. No. 9	Paul S. Neirenberg 7 West Main St., Albion, 62806	Andrew Krajec Box 336, West Salem, 62476
Effingham Members: 21-Dist. No. 7	D. G. Huelskoetter Altamont, 62411	Ernest Frank c/o St. Anthony Memorial Hospital Effingham, 62401

County	President	Secretary
Fayette Members: 10-Dist. No. 7	Enrique Lavernia St. Elmo, 62458	E. A. Kuehn 501½ West Gallatin, Vandalia, 62471
Ford Members: 13-Dist. No. 11	Clyde A. Rulison Roberts, 60962	William A. Garrett Sibley, 61773
Franklin Members: 20-Dist. No. 9	T. Kisle 502 W. Franklin, Sesser, 62884	D. P. Richerson P.O. Box 99, Christopher, 62822
Fulton Members: 27-Dist. No. 4	W. K. Wilner Cuba, 61427	O. M. Wood Ipava, 61441
Gallatin Members: 2-Dist. No. 9	Joe Bryant Ridgway, 62979	John Doyle Ridgway, 62979
Greene Members: 7-Dist. No. 6	Arthur D. Wilson Sixth Street, Carrollton, 62016	James C. Reid Fillager Mem. Clinic, Greenfield, 62044
Hancock Members: 12-Dist. No. 4	Christian W. Bruehsel Warsaw Clinic, Warsaw, 62379	Ilse Erika Bruehsel Warsaw Clinic, Warsaw, 62379
Henderson Members: 2-Dist. No. 4	Harold L. Bock Box 338, Stronghurst, 61480	Silvino Lindo, Jr. Biggsville, 61448
Henry-Stark Members: 31-Dist. No. 4	Richard Jakobi 401 S. Tenney Street, Kewanee, 61443	Luis J. Garcia Kewanee Public Hosp., Kewanee, 61443
Iroquois Members: 18-Dist. No. 11	Norman Dean Hungness 100 1st Street, Box 126, Sheldon, 60966	Delos R. Cozad Box 37, Clifton, 60927
Jackson Members: 49-Dist. No. 10	David F. Rendleman Carbondale Clinic, Carbondale, 62901	Homer H. Hanson Carbondale Clinic, Box 1030, Carbondale, 62901
Jasper Members: 3-Dist. No. 8	Don Hartrich Box 192, Newton, 62448	C. O. Absher Newton, 62448
Jefferson-Hamilton Members: 31-Dist. No. 9	David A. Nehme Doctors Park, Mt. Vernon, 62864	R. J. Dancey 601 N. 18th St., Mt. Vernon, 62864
Jersey-Calhoun Members: 11-Dist. No. 6	Herman E. Wuestenfeld 300 S. Washington St., Jerseyville, 62052	C. Maxwell Brown 2 Campus Drive, Hardin, 62047
Jo Daviess Members: 10-Dist. No. 1	Lyle A. Rachuy 323 N. Main, Stockton, 61085	Delbert O. Williams, Jr. 323 North Main St., Stockton, 61085
Johnson Members: 1-Dist. No. 9		
Kane Members: 253-Dist. No. 1 Michael FitzGerald, Exec. Sec. 214 W. State St., Geneva, 60134	Wayne Leimbach 987 Oak Avenue, Aurora, 60506	George A. Wiltrakis 606 S. Riverside Dr., St. Charles, 60174
Kankakee Members: 91-Dist. No. 11	Kurt C. Springer 555 S. Schuyler Avenue, Kankakee, 60901	Herbert P. Swartz 450 Kennedy Drive, Kankakee, 60901
Kendall Members: 8-Dist. No. 11	Stefan Wojtowycz 8 East Main, Plano, 60545	Victor H. Smith Johnson Street, Newark, 60541
Knox Members: 64-Dist. No. 4	William L. Giles 575 N. Kellogg St., Galesburg, 61401	K. K. Kleinkauf 311 E. Main St., Galesburg, 61401
Lake Members: 260-No. 1 Mrs. Julia P. Schulz, Exec. Sec. PO Box 148, Gurnee, 60031	Ralph Elson 700 Deerfield Rd., Deerfield, 60014	Lionel Ganshirt 570 Beverly Place, Lake Forest, 60045
La Salle Members: 96-Dist. No. 2	R. L. Farner 204 E. Santa Fe Avenue, Toluca, 61369	Allan L. Goslin 712 N. Bloomington, Streator, 61364
Lawrence Members: 9-Dist. No. 8 Ruth E. Gariepy, Exec. Sec. Lawrence Cty. Mem. Hosp., Lawrenceville, 62439	Robert J. Nichols P.O. Box 907, Vincennes, Ind. 47591	Charles G. Stoll 802 Jefferson St., Lawrenceville, 62439

County	President	Secretary
Lee Members: 19-Dist. No. 2	R. Silve 120 West S. Street, Franklin Grove, 61031	George Silvest 114 East Everett Ave., Dixon, 61021
Livingston Members: 27-Dist. No. 2	Theodore Mauger 416 E. Hickory, Chatsworth, 60921	Karl T. Deterding Bank of Pontiac Bldg., Pontiac, 61764
Logan Members: 22-Dist. No. 5	Gilbert E. Blaum 1301 Rutledge St., Lincoln, 62656	James Borgerson 119 S. Vine St., Mt. Pulaski, 62548
Macon Members: 133-Dist. No. 7 Mary J. Bretz, Exec. Sec., 1800 E. Lake Shore Drive, Decatur, 62521	Paul S. Reeder 1950 N. Water St., Decatur, 62526	G. Richard Locke 2300 N. Edward St., Decatur, 62521
Macoupin Members: 21-Dist. No. 6	Lee L. Johnson 426 W. Pearl St., Staunton, 62088	Robert H. Rutherford 224 E. Main St., Carlinville, 62626
Madison Members: 124-Dist. No. 6	George Thos. Wilkins 1204 27th Street, Granite City, 62040	Norman E. Taylor 95 S. 9th St., Rosewood Heights, 62024
Marion Members: 37-Dist. No. 7	Otto S. Espinosa 1515 E. Broadway, Centralia, 62801	Walter P. Plassman Box 552, Centralia, 62801
Mason Members: 6-Dist. No. 5	Dario Landazuri 125 North Orange Street, Havana, 62644	Henry W. Maxfield Mason City, 62664
Massac Members: 7-Dist. No. 9	James L. Bremer 805 Market Street, Metropolis, 62960	Ralph K. Frazier Hospital Drive, Metropolis, 62960
McDonough Members: 23-Dist. No. 4	C. L. Weston 120 N. Dudley Street, Macomb, 61455	J. L. Symmonds 301 East Jefferson, Macomb, 61455
McHenry Members: 61-Dist. No. 1 Evelyn Rosulek, Exec. Sec., 308 Kimball Ave., Woodstock, 60098	August M. Rossetti 1110 N. Green Street, McHenry, 60050	Wm. R. Larsen 13707 W. Jackson St., Woodstock, 60098
McLean Members: 84-Dist. No. 5 David W. Meister, Exec. Sec., 429 North Main Street, Bloomington, 61701	Loren Boon 429 North Main, Bloomington, 61701	George Shonat 429 N. Main, Bloomington, 61701
Menard Members: 4-Dist. No. 5	Robert J. Schafer 116 N. 5th Street, Petersburg, 62675	H. K. Moulton 119 North 7th St., Petersburg, 62675
Mercer Members: 5-Dist. No. 5	Monty P. McClellan 309 NW 2nd Street, Aledo, 61231	James W. Hastings 301 NW 2nd St., Aledo, 61231
Monroe Members: 9-Dist. No. 10	Edelberto Maglasang 109 W. Legion Street, Columbia, 62236	Ingeborg M. Kremer 854 W. Bottom, Columbia, 62236
Montgomery Members: 15-Dist. No. 5	W. T. Douglas 113 N. Wood, Hillsboro, 62056	Rudolph Sommer 515 N. Monroe, Litchfield, 62056
Morgan-Scott Members: 39-Dist. No. 6	Albyn G. Wolfe 1235 Parnassus Place, Jacksonville, 62650	Robert H. Kooiker 801 Lincoln Ave., Jacksonville, 62650
Moultrie Members: 5-Dist. No. 7	Eugene Boros Bethany, 61914	H. E. Kendall 112 E. Harrison, Sullivan, 61951
Ogle Members: 22-Dist. No. 1	Franklin D. Swan 104 North 5th Street, Oregon, 61061	Russell Zack 515 Lincoln Hwy., Rochelle, 61068
Peoria Members: 244-Dist. No. 4 David W. Meister, Exec. Sec., 427 1st National Bank Bldg., Peoria, 61602	Clarence V. Ward 427 1st National Bank Bldg., Peoria, 61602	S. M. Scalzo 427 1st National Bank Bldg., Peoria, 61602
Perry Members: 16-Dist. No. 10	Clarence E. Cawvey 20 N. Main Street, Pickneyville, 62274	Billy R. Fulk P.O. Box 245, DuQuoin, 62832

County	President	Secretary
Piatt Members: 6-Dist. No. 7	George Green 340 N. State Street, Monticello, 61856	Joseph Allman 121 North State St., Monticello, 61856
Pike Members: 9-Dist. No. 6	T. C. Bunting 321 W. Washington, Pittsfield, 62363	B. J. Rodriguez 880 Bainbridge St., Barry, 62312
Pulaski Members: 1-Dist. No. 10	A. L. Robinson Box 277, Mounds, 62964	Marvin F. Powers 107-A S. Oak Street, Mounds, 62964
Randolph Members: 16-Dist. No. 10	O. W. Pflasterer Coulterville, 62237	C. S. Schlageter 101 North Market, Sparta, 62286
Richland Members: 24-Dist. No. 8	Gerald M. Mastio Weber Medical Clinic, Olney, 62450	Richard O. Peach 1 Deveron Drive, Olney, 62450
Rock Island Members: 146-Dist. No. 4 James A. Koch, Exec. Sec., 612 Kahl Building, Davenport, 52801	Zachary J. Romeo 1705 2nd Avenue, Rock Island, 61201	Newell T. Braatelien Moline Public Hosp., Moline, 61265
St. Clair Members: 197-Dist. No. 10 Ed Belz, Exec. Director 4825 West Main Street, Belleville 62223	Wilson H. West 73rd & State, East St. Louis, 62203	Peter Soto St. Elizabeth's Hosp., Belleville, 62221
Saline-Pope-Hardin Members: 26-Dist. No. 9	S. Jankus Golconda, 62938	Warren R. Dammers A. L. Bowen Children's Center, Harrisburg, 62946
Sangamon Members: 211-Dist. No. 5 L. R. Brosi, Exec. Sec. 2100 Lindsay Road, Springfield, 62704	Douglas M. Gover 701 North Walnut St., Springfield, 62702	John Teich 1315 N. 5th Street, Springfield, 62702
Schuyler Members: 3-Dist. No. 4	R. R. Dohner 103 W. Washington, Rushville, 62681	Henry C. Zingher Rushville Clinic, Rushville, 62681
Shelby Members: 8-Dist. No. 7	Otto Kauder Findlay, 62534	Smith D. Taylor 520 Penns Avenue, Windsor, 61957
Stephenson Members: 39-Dist. No. 1	J. E. Madden 420 S. Harlem Avenue, Freeport, 61032	R. Samuel Hoover Box 573, Freeport, 61032
Tazewell Members: 46-Dist. No. 5 David W. Miester, Exec. Sec. 427 1st National Bank Bldg., Peoria, 61602	Nelson A. Wright III 427 1st National Bank Bldg., Peoria, 61602	Robert M. Wright 427 1st National Bank Bldg., Peoria, 61602
Union Members: 7-Dist. No. 10	Robert L. Rader 200 N. Main St., Anna, 62906	William H. Whiting Box 410, Anna 62906
Vermilion Members: 84-Dist. No. 8	W. R. Elghammer 733 N. Logan Avenue, Danville, 61832	L. W. Tanner 7 North Virginia, Danville, 61832
Wabash Members: 7-Dist. No. 9	T. R. Young 512 Market Street, Mount Carmel, 62863	C. J. Johns 114 West 5th St., Mt. Carmel, 62863
Warren Members: 11-Dist. No. 4	Douglas W. Taylor 120 North A Street, Monmouth, 61462	Glenn W. Chamberlin 219 E. Euclid Street, Monmouth, 61462
Washington Members: 3-Dist. No. 10	Jerry L. Beguelin Box 197, Irvington, 62848	Jerry L. Beguelin Box 197, Irvington, 62848
Wayne Members: 6-Dist. No. 9	Arthur Marks 101 E. Center Street, Fairfield, 62837	D. A. Gershenson 308 E. Main St., Fairfield, 62837
White Members: 7-Dist. No. 9	John Stricklin W. Main Street, Carmi, 62821	Stanley B. Abelson S. Plum Street, Carmi, 62821
Whiteside Members: 37-Dist. No. 2	Erwin J. Roubicek 307 1st Avenue, Sterling, 61081	Edward D. Greaves Sterling Rock Falls Clinic, 101 E. Miller Road, Sterling, 61081

County	President	Secretary
Will-Grundy Members: 197-Dist. No. 11 Don M. Kline, Exec. Sec. 58 N. Chicago St., Joliet 60431	Richard T. Calosio 330 N. Madison Street, Joliet, 60435	Guy A. Pandola 333 N. Madison St., Joliet, 60435
Williamson Members: 29-Dist. No. 9	Edward L. Corder, Jr. 801 North Market St., Marion, 62959	H. V. Fine 110 N. Division St., Carterville, 62918
Winnebago Members: 286-Dist. No. 1 Donald A. Westbrook, Exec. Administrator 310 N. Wyman St., Rockford, 61101	R. Glenn Smith 1221 E. State Street, Rockford, 61103	Donald P. Feeney 2300 N. Rockton Ave., Rockford, 61101
Woodford Members: 9-Dist. No. 2	Howard Thomas Barrett 200 E. 6th Street, Minonk, 61760	James Riley 109 S. Major St., Eureka, 61530

No Organized County Society

Brown
Johnson
Marshall
Putnam

Joint County Societies

Coles-Cumberland
Henry-Stark
Jefferson-Hamilton
Jersey-Calhoun
Morgan-Scott
Saline-Pope-Hardin
Will-Grundy

Chicago Medical Society

President: Andrew J. Brislen
6060 South Drexel Blvd., Chicago 60637
Secretary: Charles P. McCartney
12412 S. 74th Avenue, Palos Heights 60463
Executive Vice-President: George F. Lull
310 South Michigan Avenue, Chicago 60604
Executive Director: Robert J. Lindley
310 South Michigan Avenue, Chicago 60604
Members: 6,776-District No. 3

Branch Officers

AUX PLAINES BRANCH
President: Robert C. Muehrcke
518 N. Austin Blvd., Oak Park 60303
Secretary: Meredith B. Murray
414 S. Oak Park, Oak Park 60302

CALUMET BRANCH
President: Edwin L. Falloon
9450 S. Francisco Ave., Evergreen Park 60642
Secretary-Treasurer: Thomas S. Patricoscki
11110 S. Sawyer Ave., 60655

DOUGLAS PARK BRANCH
President: Frank M. Lhotka
6005 Cermak Rd., Cicero 60650
Secretary: Kent F. Borkovec
3340 S. Oak Park Ave., Berwyn 60402

ENGLEWOOD BRANCH
President: Kozme F. Kapov
4255 W. 63rd St., 60629
Secretary-Treasurer: Stanley Budrys
2751 W. 51st St., 60632

NORTH SUBURBAN BRANCH
President: James R. Dillon
1580 Sherman Ave., Evanston 60201
Secretary-Treasurer: Daniel J. Murphy
2510 Ridgeway, Evanston 60201

IRVING PARK SUBURBAN BRANCH
President: Vincent C. Sarley
811 W. Wellington Ave., 60657
Secretary: Martin P. Meisenheimer
107 E. McDonald Rd., Prospect Heights 60070

JACKSON PARK BRANCH
President: Mathew W. Kobak
1700 E. 56th St., 60637
Secretary-Treasurer: Helen Cook Newman
1534 E. 59th St., 60637

NORTH SHORE BRANCH
President: David T. Petty
30 N. Michigan Ave., 60602
Secretary: Arthur Peterson
2760 W. Foster, 60625

NORTH SIDE BRANCH
President: Bernard T. Peele
2 W. Chicago Ave., 60610
Secretary-Treasurer: Joseph C. Sherrick
303 E. Superior St. 60611

NORTHWEST BRANCH
President: E. J. Kotanyi
1200 N. Ashland Ave., 60622
Secretary-Treasurer: Victor C. Rueda
1802 W. Chicago Ave., 60622

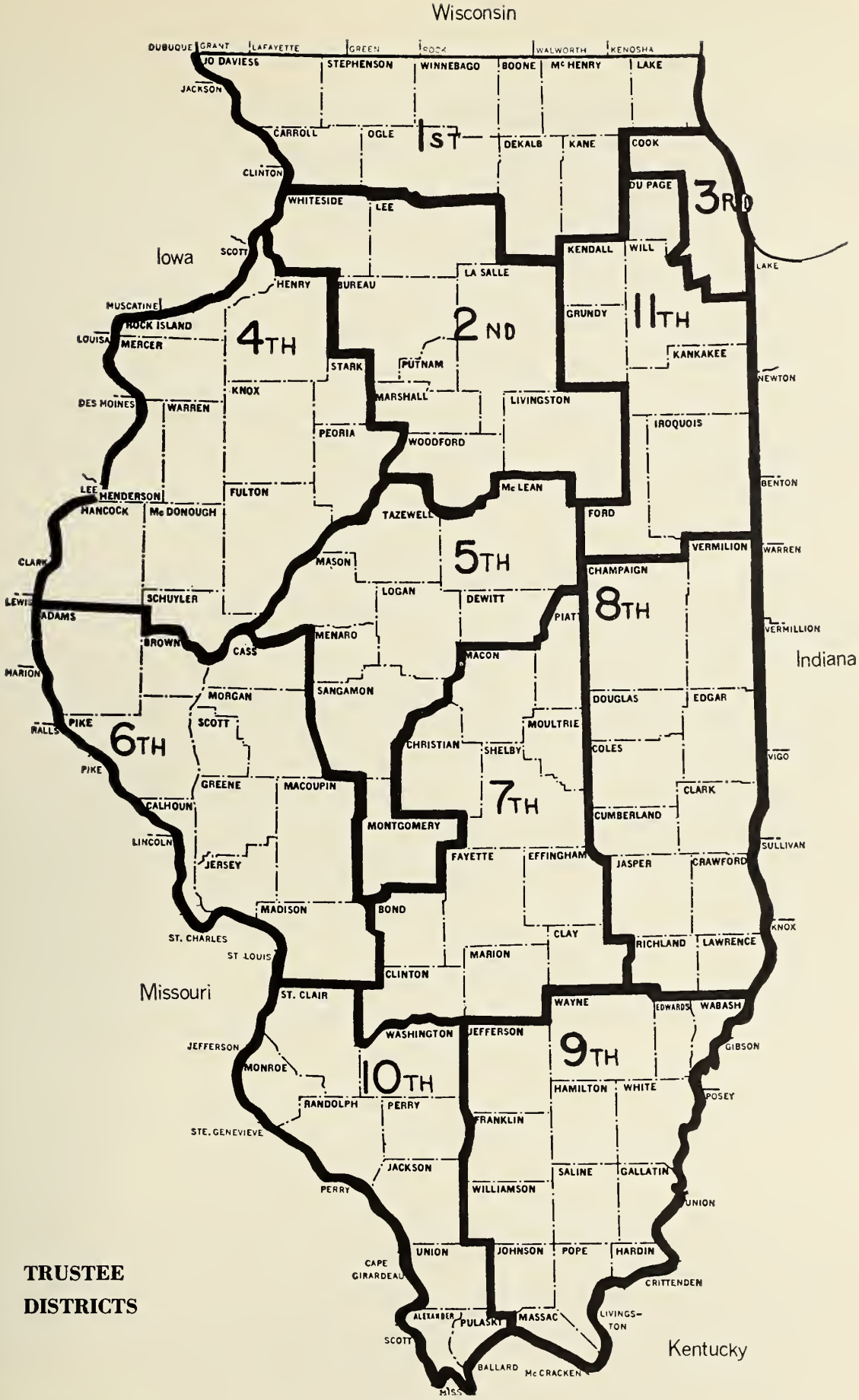
SOUTH CHICAGO BRANCH
President: Anthony G. Cesare
9204 Commercial Ave. 60617
Secretary-Treasurer: Abram I. Doktorsky
7257 S. Jeffery Ave., 60649

SOUTH SIDE BRANCH
President: Kermit Mehlinger
4901 Drexel Blvd. 60615
Secretary: Otto J. Keller
5825 S. Dorchester Ave. 60637

SOUTHERN COOK COUNTY BRANCH
President: William E. Ricketts
23450 Western Ave., Park Forest 60466
Secretary-Treasurer: Roman Filipowicz
16168 Drexel, South Holland 60473

STOCK YARDS BRANCH
President: Maurice M. Hoeltgen
1836 West 87th St. 60620
Secretary-Treasurer: Edwin J. Lukaszewski
1213 W. 51st St. 60609

WEST SIDE BRANCH
President: William J. Tansey
414 S. Oak Park Ave., Oak Park 60303
Secretary-Treasurer: Eugene T. Hoban
6429 North Ave., Oak Park 60302


Wisconsin
DUBUQUE
GRANT
LAFAYETTE
GREEN
ROCK
WALWORTH
KENOSHA
JO DAVIESS
STEPHENSON
WINNEBAGO
BOONE
Mc HENRY
LAKE
JACKSON
CARROLL
OGLE
1ST
DEKALB
KANE
COOK
CLINTON
DU PAGE
3RD
WHITESIDE
LEE
Iowa
SCOTT
KENDALL
WILL
LAKE
HENRY
BUREAU
LA SALLE
MUSCATINE
GRUNDY
11TH
ROCK ISLAND
2ND
LOUISA
MERCER
4TH
KANKAKEE
STARK
PUTNAM
NEWTON
KNOX
DES MOINES
WARREN
MARSHALL
LIVINGSTON
IROQUOIS
PEORIA
WOODFORD
LEE
HENDERSON
FULTON
Mc LEAN
BENTON
HANCOCK
Mc DONOUGH
TAZEWELL
FORD
VERMILION
WARREN
CLARK
MASON
5TH
CHAMPAIGN
LOGAN
DEWITT
8TH
LEWIS
SCHUYLER
ADAMS
PIATT
VERMILLION
BROWN
CASS
MENARD
Indiana
MACON
MARION
MORGAN
SANGAMON
DOUGLAS
EDGAR
RALLS
PIKE
SCOTT
MOULTRIE
6TH
CHRISTIAN
SHELBY
COLES
VIGO
PIKE
GREENE
MACOUPIN
7TH
CLARK
CALHOUN
CUMBERLAND
MONTGOMERY
LINCOLN
SULLIVAN
JERSEY
FAYETTE
EFFINGHAM
JASPER
CRAWFORD
MADISON
BOND
CLAY
KNOX
ST. CHARLES
ST LOUIS
MARION
RICHLAND
LAWRENCE
CLINTON
Missouri
ST. CLAIR
WAYNE
EDWARDS
WABASH
WASHINGTON
JEFFERSON
JEFFERSON
9TH
GIBSON
MONROE
10TH
HAMILTON
WHITE
POSEY
RANDOLPH
PERRY
FRANKLIN
STE. GENEVIEVE
JACKSON
SALINE
GALLATIN
PERRY
WILLIAMSON
UNION
UNION
JOHNSON
POPE
HARDIN
CAPE GIRARDEAU
CRITTENDEN
ALEXANDER
PULASKI
MASSAC
LIVINGS-TON
SCOTT
Kentucky
BALLARD
McCRACKEN
TRUSTEE DISTRICTS

TRUSTEE DISTRICT COMMITTEES

First District

Joseph L. Bordenave, Geneva, *Trustee*
Counties of Boone, Carroll, DeKalb, Jo Daviess, Kane, Lake, McHenry, Ogle, Stephenson, Winnebago

Ethical Relations Committee	Term Expires
John H. Steinkamp, Belvidere, *Chairman*	1972
Gerald Liesen, St. Charles	1973
James C. Ellis, DeKalb	1974
E. J. McKinney, Rockford	1972

Peer Review Committee

Russell Zack, Rochelle, *Chairman*	1973
R. Gregory Green, Rockford	1972
Walter J. Reedy, Waukegan	1972
John E. Madden, Freeport	1973
Rodney Nelson, Geneva	1972
Erwin A. Schilling, Rockford	1972
R. E. Whitsitt, Rockford	1972

Second District

Allan L. Goslin, Streator, *Trustee*
Counties of Bureau, LaSalle, Lee, Livingston, Marshall, Putnam, Whiteside, Woodford

Ethical Relations Committee	Term Expires
K. Dexter Nelson, Princeton, *Chairman*	1974
Ralph Bailey, Ottawa	1972
Tim Sullivan, Sterling	1973

Peer Review Committee

K. M. Nelson, Princeton, *Chairman*	1972
M. D. Burnstine, Sterling, *Co-Chairman*	1973
James B. Aplington, LaSalle	1973
LaMonte Ballard, Sterling	1973
Francis J. Brennan, Utica	1973
Silvio Davito, Spring Valley	1973
Bernard J. Doyle, LaSalle	1973
Donald Edwards, Dixon	1973
William Ehling, Streator	1974
Julius Kolis, Dixon	1973
P. Lymberopoulis, Dixon	1973
Edward Murphy, Dixon	1974
Rowland Musick, Mendota	1973
Joseph Phifer, Eureka	1972
Goodwin Taraason, Peru	1973
Louis Tarsinos, Princeton	1973
Philip Terry, Kewanee	1973
Theodore W. Wagenknecht, Streator	1973

Third District

David S. Fox, Olympia Fields, *Trustee*
Robert T. Fox, Glenview, *Trustee*
Eugene T. Hoban, Oak Park, *Trustee*
Fredric D. Lake, Evanston, *Trustee*
William M. Lees, Lincolnwood, *Trustee*
George Shropshear, Chicago, *Trustee*
Philip G. Thomsen, Dolton, *Trustee*
Frederick E. Weiss, Harvey, *Trustee*
Warren Young, Chicago, *Trustee*
No district committees are appointed

Fourth District

Fred Z. White, Chillicothe, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Warren

Ethical Relations Committee	Term Expires
Richard Icenogle, Roseville, *Chairman*	1974
John Bowman, Abingdon	1973
George Burke, Rock Island	1972

Peer Review Committee

Russell Jensen, Monmouth, *Chairman*	1973
William Daugherty, Moline	1972
Donald Dexter, Macomb	1974
G. W. Giebelhausen, Peoria	1972
James C. Parsons, Geneseo	1973
Clarence Ward, Peoria	1972

Fifth District

A. Edward Livingston, Bloomington, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon, Tazewell

Ethical Relations Committee	Term Expires
William W. Curtis, Springfield, *Chairman*	1974
Arthur Conklin, Bloomington	1973
Jack Means, Mason City	1972

Peer Review Committee

James Borgerson, Mt. Pulaski, *Chairman*	1974
Robert Price, Bloomington, *Co-Chairman*	1974
Ross Billiter, Litchfield	1973
George Irwin, Bloomington	1973
John G. Meyer, Springfield	1972
Alton J. Morris, Springfield	1973
Robert B. Perry, Lincoln	1973
Robert Schaefer, Petersburg	1972
James Weiner, Pekin	1973

Sixth District

Mather Pfeiffenberger, Alton, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin, Madison, Morgan, Pike, Scott

Ethical Relations Committee	Term Expires
Bernard Baalman, Hardin, *Chairman*	1972
George F. Dietz, Granite City	1973
Edward K. DuVivier, Alton	1974
Joseph J. Grandone, Gillespie	1974

Peer Review Committee

Robert R. Hartman, Jacksonville, *Chairman*	1972
Meyer Shulman, Pittsfield, *Co-Chairman*	1974
E. C. Bone, Jacksonville	1973
Jude A. Caselton, Carrollton	1972
Bruno DeSulis, Beardstown	1974
Robert C. Murphy, Quincy	1973
Frank B. Norbury, Jacksonville	1972
James Reid, Greenfield	1974
James W. Sutherland, Quincy	1974

Seventh District

Arthur F. Goodyear, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby

Ethical Relations Committee	Term Expires
Carl Sandburg, Decatur, *Chairman*	1973
Max Hirschfelder, Centralia	1974
E. H. Rames, Vandalia	1972

Peer Review Committee

Stanley Moore, Vandalia, *Chairman*	1973
E. C. Bartelsmeyer, Taylorville	1974
H. O. Hoffman, Decatur	1974
Walter P. Plassman, Centralia	1973
William Sargeant, Effingham	1973

Eighth District

Eugene P. Johnson, Casey, *Trustee*
Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermillion

Ethical Relations Committee	Term Expires
Mack W. Hollowell, Charleston, *Chairman*	1974
James H. Pass, Olney	1972
Alan M. Taylor, Danville	1973

Peer Review Committee

A. R. Brandenberger, Danville, *Chairman*	1974
James W. Landis, Olney, *Co-Chairman*	1974
Eugene Johnson, Casey	1972
E. A. Kendall, Mattoon	1973
George T. Mitchell, Marshall	1972
Gordon Sprague, Paris	1973

Ninth District

Charles K. Wells, Mt. Vernon, *Trustee*
Counties of Edwards, Franklin, Gallatin, Hamilton, Hardin, Jefferson, Johnson, Massac, Pope, Saline, Wabash, Wayne, White, Williamson

Ethical Relations Committee	Term Expires
Andrew Krajec, West Salem, *Chairman*	1973
Cyril Anslinger, Mt. Vernon	1972
Denton Farrell, Eldorado	1974

Peer Review Committee

C. J. Jannings, III, Fairfield, *Chairman*	1973
Philip Boren, Carmi	1974
Herbert Fine, Carterville	1972
Ernest Lowenstein, Mt. Carmel	1973
A. Watson Miller, Herrin	1972
Warren Tuttle, Harrisburg	1974

Tenth District

Willard C. Scrivner, East St. Louis, *Trustee*
Counties of Alexander, Jackson, Monroe, Perry, Pulaski, Randolph, St. Clair, Union, Washington

Ethical Relations Committee	Term Expires
A. L. Robinson, Mounds, *Chairman*	1973
William Borgsmiller, Murphysboro	1972
Peter Soto, Belleville	1974

Peer Review Committee

Joseph A. Petrazio, Murphysboro, *Chairman*	1973
George Cutridge, DuQuoin, *Co-Chairman*	1973
Charles Baldree, Belleville	1973
Eli Borken, Carbondale	1973
R. W. Jost, Waterloo	1972
B. Kinsman, DuQuoin	1973
Robert Rader, Anna	1974
R. E. Schettler, Red Bud	1974
William H. Walton, Belleville	1972
Charles L. Yarbrough, Cairo	1973

Eleventh District

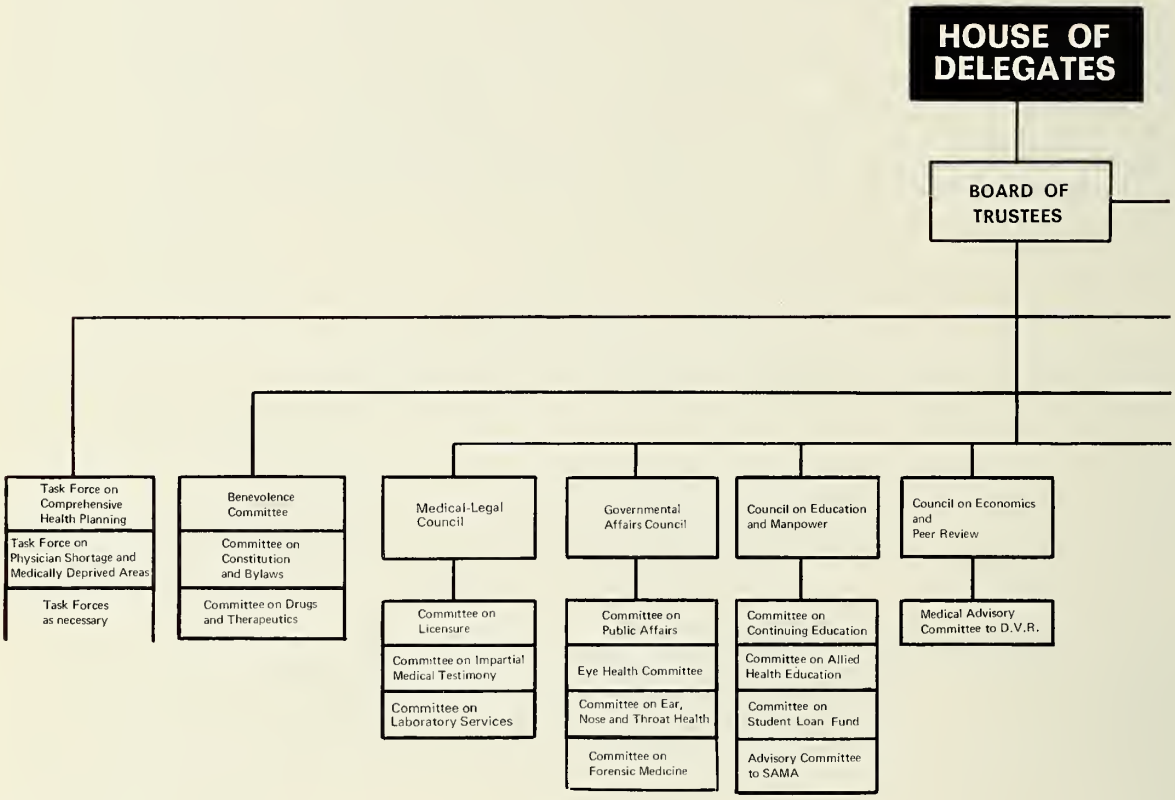
Joseph R. O'Donnell, Glenn Ellyn, *Trustee*
Counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall, Will

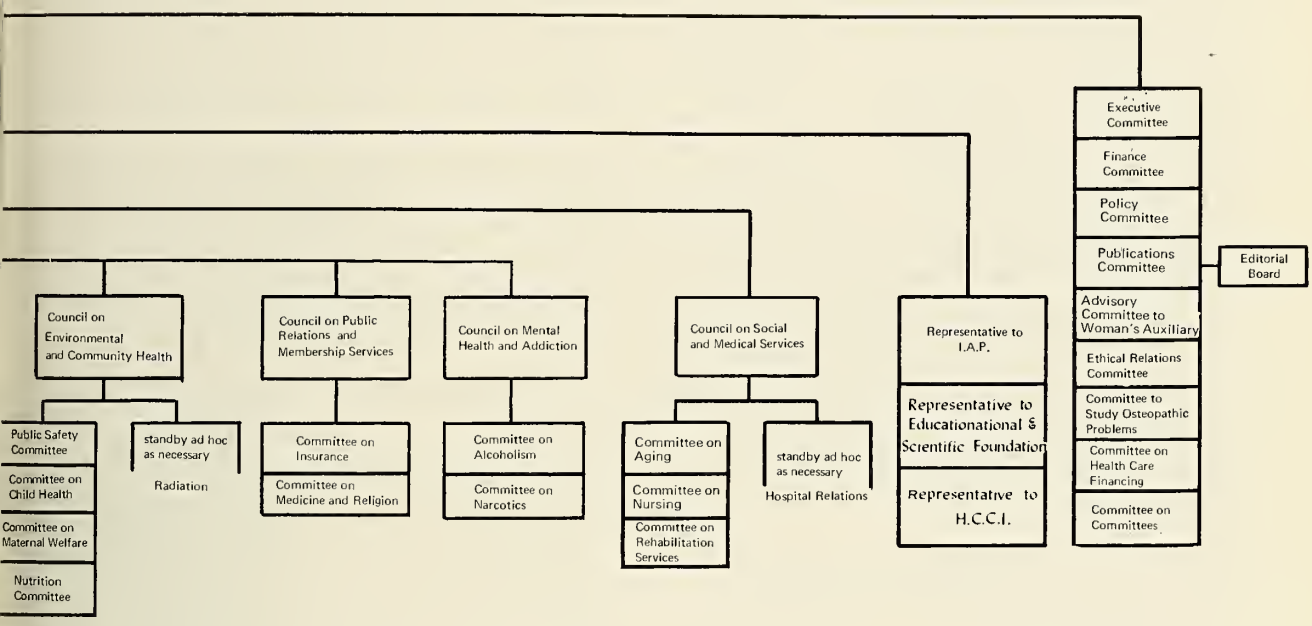
Ethical Relations Committee	Term Expires
James Ryan, Kankakee, *Chairman*	1972
John Bowden, Joliet	1973
Lawrence D. Lee, Manhattan	1973

Peer Review Committee

James Campbell, Wheaton, *Chairman*	1972
James E. Dailey, Watseka	1972
James Lambert, Joliet	1973
Guy Pandola, Joliet	1972
William C. Perkins, West Chicago	1973
Julius Schweitzer, Hinsdale	1974
Victor Smith, Newark	1974

ISMS Organization





Councils of the Illinois State Medical Society

Committees of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees, and are assigned to one of eight councils. The councils are similarly appointed and are composed of committee chairmen and such other members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Some committees may report directly to the board and are not assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, President-Elect, Speaker of the House, and Chairman of the Board are, by virtue of their office, ex-officio members of all groups.

COUNCIL ON ECONOMICS & PEER REVIEW

Glen E. Tomlinson, *Chairman*
4 Lincoln Professional Park, Lincoln 62626
Fred A. Tworoger, *Vice-Chairman*
(Chairman, IDPA Med. Adv. Com.)
4753 Broadway, Chicago 60640
Charles E. Baldree, Jr.
26 E. Washington, Belleville 62220
Robert Becker
58 N. Chicago, Joliet 60431
Stanley Bobowski
407 S. Fourth, Champaign 61820
Eli Borkon
(Chairman, Adv. Com. to DVR)
8 Pinewood, Carbondale 62901
Edward DuVivier
1900 Brown St., Alton 62002
John L. Eaton
4204-35th Ave., Moline 61265
Earl E. Fredrick, Jr.
10830 S. Halsted, Chicago 60628
R. Gregory Green
1355 Charles St., Rockford 61108
Burton Jacobson
3425 W. Peterson, Chicago 60645
John P. Marty
1315 N. 5th St., Springfield 62702
Don Michels
533 W. North, Elmhurst 60612
Robert Muehrcke
518 N. Austin, Oak Park 60302
Maynard Shapiro
7531 Stony Island, Chicago 60649
Herbert J. Svab
906 Calle View Dr., LaGrange 60525
Earl Walker
215 E. Locust, Harrisburg 62946

CONSULTANTS

Joseph R. O'Donnell
444 Park, Glen Ellyn 60137
Fred Z. White
723 N. Second Street, Chillicothe 61523

SAMA REPRESENTATIVES

Joyce Root
2801 S. King Dr., Apt. 912, Chicago 60616
James Whitehouse
15 W. Delaware Place, Chicago 60610

STAFF: Joseph J. Lotharius

Committees:

Advisory to the Division of Vocational Rehabilitation

Responsibilities and Purposes:

The Council on Economics and Peer Review shall: 1) Serve as the appellate body for peer review in the state to consider cases appealed from local committees involving the quality and quantity of medical care; 2) Provide a channel of communication between ISMS and government intermediaries, the health insurance industry, Blue Cross-Blue Shield Plans and similar organizations in matters of mutual concern; 3) Initiate, explore and bring to the attention of the Board of Trustees suggested policies and philosophies relating to medical service in Illinois; 4) Advise the staff in socio-economic issues and further the health and welfare of the public by seeking continuous improvement of medical service in Illinois; 5) Advise the Illinois Division of Vocational Rehabilitation and other state health agencies on matters pertaining to fees and the quality of medical services.

COUNCIL ON EDUCATION AND MANPOWER

Jack L. Gibbs, *Chairman*
175 S. Main St., Canton 61520
Herschel L. Browns (Continuing Education)
4600 N. Ravenswood, Chicago 60640
Lawrence L. Hirsch
836 Wellington, Chicago 60657
Richard Magraw (Allied Health Education)
1853 W. Polk St., Chicago 60612
R. Charles Oldfield
40 S. Clay, Hinsdale 60521
George O. Dohrmann
3000 Logan Blvd., Chicago 60647
Rex McMorris
619 N. E. Glen Oak Ave., Peoria 61603
John Holland
700 N. 7th c/o Physicians Group, Springfield 62702
L. P. Johnson
1335 Charles St., Rockford 61108
T. Howard Clarke (Advisory Comm. to SAMA)
836 W. Wellington, Chicago 60657
Donald Stehr (Student Loan Fund)
102 E. Market, Havana 62644

CONSULTANTS

Robert T. Fox
2136 Robin Crest Lane, Glenview 60025
William M. Lees
6518 N. Nokomis, Lincolnwood 60646
Fred Z. White
723 N. 2nd St., Chillicothe 61523

SAMA REPRESENTATIVES

David Lark
3726 W. Cornelia, Chicago 60618
Michael Youssi
709 S. Ada, Chicago 60607

MEDICAL SCHOOL REPRESENTATIVES

Chicago Medical School
James Shaffer
2020 Ogden Ave., Chicago 60612
Loyola Medical School
William B. Rich
2160 S. 1st, Maywood 60153
Northwestern Medical School
Edward S. Petersen
303 E. Chicago, Chicago 60611
Rush Medical School
John Graettinger
Rush-Presbyterian-St. Lukes
Medical Center, Chicago 60612
Univ. of Chicago-Pritzker School of Medicine
Richard Landau
950 E. 59th, Chicago 60680
University of Illinois
Richard Magraw
Southern Illinois University Medical School
Richard H. Moy
715 E. Carpenter, Springfield 62702
Peoria Medical School-Univ. of Ill.
Nicholas J. Cotsonas
U. of I. Med. Center, Box 6998, Chicago 60680
Rockford Medical School-Univ. of Ill.
Robert L. Evans
1601 Park View, Rockford 61101

STAFF: Richard A. Ott

Responsibilities and Purposes:

The Council on Education and Manpower shall (1) study and evaluate all phases of medical education including the development of programs approved by the House of Delegates for the provision of a continuing supply of well-qualified physicians; (2) study and evaluate education relating to the health professions and services important to medicine, including the development of programs approved by the House of Delegates for the provision of a continuing supply of well qualified personnel in these fields; (3) carry to the deans of the medical schools recommendations from the viewpoint of the practicing physician; (4) study, evaluate and criticize the postgraduate programs of ISMS and other organizations; (5) be available to advise and cooperate with the Department of Registration and Education of the State of Illinois; (6) serve as liaison between ISMS and the Student American Medical Association; and (7) administer the Student Loan Fund program which is operated jointly by ISMS and the Illinois Agricultural Association.

Committees:

Advisory to SAMA
Allied Health Education
Continuing Education
Student Loan Fund

COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

Edward A. Piszczek, *Chairman*
6410 N. Leona, Chicago 60646
James P. Campbell (Public Safety)
322 N. Blanchard, Wheaton 60187
Eugene F. Diamond (Nutrition)
2160 S. 1st, Maywood 60153
Robert Hartman (Maternal Welfare)
1515A Walnut, Jacksonville 62650
John S. Hyde
715 Lake, Oak Park 60301
Ralph S. Kunstadter (Child Health)
664 N. Michigan, Chicago 60611
Arthur E. Sulek
Illinois Dept. of Public Health
4302 N. Main, Rockford 61103
Dan Butcher
365 Laurel Ave., Elmhurst 60126
Howard C. Burkhead (Radiation)
2650 Ridge, Evanston 60201

CONSULTANT

Warren W. Young
3450 Haweswood, Crete 60417

AUXILIARY REPRESENTATIVE

Mrs. William Schowengerdt
Route #2, S. Prospect Rd., Champaign 61820

SAMA REPRESENTATIVES

Alan Lee Ansel
9157 S. Chappel, Chicago 60617
Robert Pollnow
2326 W. 48th St., Chicago 60609

STAFF: Richard A. Ott

Responsibilities and Purposes:

The Council on Environmental & Community Health shall cooperate with the Illinois Department of Public Health in specific areas. Its responsibilities shall include the maintenance, protection and improvement of the health of the people of Illinois through organized community efforts.

It shall serve as a source of information on chronic illness and communicable diseases and cooperate with institutions and voluntary health agencies in disseminating such information.

It is responsible for medicine's interest in the relationship of man to his surroundings, particularly air, water and soil pollution; health problems related to population growth, urbanization and technological development bearing on the ecology of man.

The council also shall be concerned with diseases and problems associated with occupational and industrial health, cooperate with the Council on Occupational Health of AMA, Industrial Medical Association and similar state agencies and to recommend to the State of Illinois Workman's Compensation Board medical procedures designed to assist the board in the evaluation of claims.

Committees:

Public Safety
Child Health
Maternal Welfare
Nutrition
Radiation *ad hoc*

GOVERNMENTAL AFFAIRS COUNCIL

Alfred J. Faber, *Chairman*
2100 Swainwood Dr., Glenview 60025
John J. Ballenger (E.N.T.)
723 Elm St., Winnetka
Edward G. Ference
932 S. 2nd, Springfield 62704
Frank Holman
Christian Welfare Hospital, E. St. Louis 62201
Warren W. Kreft
940 Lee St., Des Plaines 60016
James Laidlow
1005 Lincolnshire Dr., Champaign 61820
Colman J. O'Neill
350 Sherwood Ct., LaGrange Pk. 60525
John W. Ovitz (Public Affairs)
204 W. Elm St., Sycamore 60178
Warren Tuttle
203 N. Vine St., Harrisburg 62946
James Ryan
401 N. Wall, Kankakee 60901

CONSULTANTS

C.J. Jannings, III
1001 Center St., Fairfield
Frederic D. Lake
1041 Michigan Ave., Evanston 60202
William M. Lees
6518 Nokomis, Lincolnwood 60646
Robert Fox
2136 Robin Crest, Glenview 60025
George Shropshear
1525 E. 53rd St., Chicago

Auxiliary Representative
Mrs. James Kopriva
475 Windsor Dr., Antioch 60002
SAMA Representative
Mark Brakke
1620 Wallen, Chicago 60626
Staff: Timothy D. Selleck, William Kempiners, Betty Kararo

Responsibilities and Purposes

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Cooperate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Public Affairs
Eye Health
Ear, Nose & Throat Health Committee
Forensic Medicine Committee

MEDICAL-LEGAL COUNCIL

Clinton L. Compere, *Chairman*
737 N. Michigan, Chicago 60611
Ross Hutchison (Licensure)
126 E. 9th, Gibson City 60936
George Alvary (CORR. "PERSONAL)
1110 N. Green, McHenry 60050
David T. Petty
30 N. Michigan Ave. Chicago 60602
Vincent Sarley, M.D. (Impartial Medical Testimony)
682 Pine, Deerfield 60015
Herman Wing
400 E. Randolph, Chicago 60601
Leonard C. Arnold
1700 W. Lawrence Ave, Chicago 60640
Theodore Balsam
4640 N. Marine Dr. Chicago 60640
James Habegger (Laboratory Services)
32 S. Lincoln, Geneva 60134
Consultants
Joseph L. Bordenave
1665 South St., Geneva 60134
Frederic Lake
2520 N. Lakeview, Chicago 60614
William Lees
6518 N. Nokomis, Lincolnwood 60646
Allan Goslin
712 N. Bloomington, Streator 61634
William Adams
55 E. Erie, Chicago 60611
SAMA Representatives
Gregory Keller
825 S. Lathrop, Forest Park 60130
Edward Quebbeman
1926 W. Harrison, Chicago
STAFF: H. Michael Wild

Responsibilities and Purposes:

The functions of the Medical Legal Council are to 1) maintain liaison with the Bar Association; 2) supervise the activities of the Council's three committees; and 3) to educate the members of the profession in medico-legal affairs.

The Council members include the Chairmen of the Licensure, IMT, and Laboratory Services Committees, to facilitate cooperation and coordination of activities. The Council further cooperates fully with the AMA for purposes of coordinating programming.

Committees:

Impartial Medical Testimony
Laboratory Services
Licensure

COUNCIL ON MENTAL HEALTH AND ADDICTION

Marshall A. Falk, *Chairman*
4700 N. Clarendon, Chicago 60640
Nathaniel S. Apter
111 N. Wabash, Chicago 60602
Milton C. Baumann
725 S. 2nd St., Springfield 62704
Irving Frank
135 S. Sacramento, Sycamore 60178
Abraham Gelperin (Alcoholism)
Oak Forest Hospital,
159th & Cicero, Oak Forest 60452
Richard Graff
204 Julie Drive, Box 391, Kankakee 60901
Walter P. Plassman
Box 552, Centralia 60901
Joseph H. Skom (Narcotics)
707 N. Fairbanks Ct., Chicago 60611
Alex Spadoni
2301 Glenwood Ave., Joliet 60435
W. David Steed
1011 Lake St., Suite 423-4, Oak Park 60301
Donovan Wright
135 S. Kenilworth, Elmhurst 60126
Ronald Schlensky
251 E. Chicago, Suite 930, Chicago 60611
Howard D. Kurland
636 Church Street, Evanston 60201
Robert DeVito
1200 S. First, Hines 60141
Patrick Ebenhoeh, *Liaison of Illinois Psych. Society*
518 Echo Lane, Glenview 60026
Consultants
J. Ernest Breed
55 E. Washington, Chicago 60602

Albert Glass
Ill. Dept. of Mental Health
100 N. La Salle, Chicago

Vladmir Urse
Chicago Board of Health
118 N. Clark, Chicago 60601

Earl U. Solon
720 N. Michigan Blvd., Chicago 60611

SAMA Representatives

David Shapiro
633 S. Lafflin, Chicago 60607

Richard Jacobs
1720 N. Hudson, Chicago 60614

Auxiliary Representative

Mrs. John Koenig
2518 Oakwood Dr., Olympia Fields 60461

Staff: Richard A. Ott

Responsibilities and Purposes:

The responsibilities of this council are as follows: It shall serve as a source of information on mental health matters for the ISMS. It shall evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area. It shall also cooperate with institutions and voluntary health agencies in disseminating information on mental health subjects to the profession and the public. It shall be on the alert for misleading or fallacious programs and information which need correcting for the protection of the public.

The Council shall be especially concerned with the problems of alcoholism and drug abuse.

Committees:

Alcoholism
Narcotics

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Charles J. Weigel, *Chairman*
7579 Lake St., River Forest 60305

Paul Biedenharn
Medical Arts Building, New Baden 62265

Lawrence Knox (Insurance)
600 E. Main, Olney 62450

Charles W. Pfister (Medicine & Religion)
5511 N. Harlem, Chicago 60656

Catherine L. Dobson
5842 Stony Island Ave., Chicago 60637

Lee F. Winkler
850 S. 4th, Springfield 62703

M. Douglas Hursh
1492 N. Main St., Wheaton 60187

Consultants

Paul W. Sunderland
214 N. Sangamon St., Gibson City 60936

Fredric D. Lake
1041 Michigan Ave., Evanston 60202

SAMA Representatives

Henry Covelli
414 N. Taylor, Apt. 3H, Oak Park 60302

Roger Rodgers
5540 Winthrop, Apt. #3, Chicago 60640

Auxiliary Representative

Mrs. John Ovitz
427 S. Main, Sycamore 60178

Staff: Bob Westerbeck

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The Council shall be responsible for all insurance programs sponsored by ISMS on behalf of the membership. It shall also be responsible for all other membership services.

Committees:

Medicine & Religion
Insurance

COUNCIL ON SOCIAL & MEDICAL SERVICES

Thomas R. Harwood, *Chairman*
333 E. Huron, Chicago 60611

William A. Hutchison (Nursing)
4753 N. Broadway, Chicago 60640

Kenneth A. Hurst
157 S. Lincoln, Aurora 60505

Joel S. Rosen (Rehabilitation Services)
401 E. Ohio, Chicago 60611

Paul Theobald
1210 Towanda Plaza, Bloomington 61801

Thomas T. Tourlentes (Aging)
1801 N. Seminary St., Galesburg 61401

Julian Buser (Hospital Relations ad hoc)
4601 State St., E. St. Louis 62205

Consultant

L. T. Fruin
5 Citizen's Square, Normal 61761

SAMA Representatives

Ned Bartlet
423 W. Belden, Chicago 60657

Staff: Robert Westebeck

Responsibilities and Purposes:

The Council on Social and Medical Services shall initiate and implement programs on health and socio-economic problems of the aging and shall maintain liaison with other health professionals and health-oriented groups related to the fields of aging, nursing, hospital services, rehabilitation services and government health care programs. Special attention should be given to quality of care given by health care facilities such as hospitals, nursing homes and extended care facilities.

Committees:

Aging
Nursing
Rehabilitation Services
Hospital Relations *ad hoc*

Committees

The following committees have been appointed for the year 1971-1972. Each committee is assigned to a council for reporting purposes, except those that are composed entirely of trustees, or which, for reasons of efficiency and control, report directly to the Board of Trustees.

COMMITTEE ON AGING
(Council on Social & Medical Services)

Thomas T. Tourlentes, *Chairman*
1801 N. Seminary St., Galesburg 61401

James R. Durham
601-5th Ave., Mendota 61342

Sherman Kaplitz
609 Leamington, Wilmette 60091

Bertram Moss
Chief of Geriatric Medicine
Oak Forest Hospital
15900 S. Cicero, Oak Forest 60452

Clyde Rulison
Box 38, Roberts 60932
CONSULTANT

A. E. Livingston
219 N. Main, Bloomington 61701
AUXILIARY REPRESENTATIVE
Mrs. Mitchell Spellberg
1212 N. Lake Shore Dr., Chicago 60610
STAFF: Maury M. Breecher

Responsibilities and Purposes:

The Committee on Aging shall consider matters related to the broad field of aging, including socio-economic as well as medical services. The committee shall maintain liaison with other agencies having a similar interest, including the American Medical Association's Committee on Aging.

COMMITTEE ON ALCOHOLISM
(Council on Mental Health and Addiction)

Abraham Gelperin, *Chairman*
Oak Forest Hospital, Oak Forest 60452

Charles L. Anderson
120 N. Oak Street, Hinsdale 60521

David Stinson
2126 Jonquil Place, Rockford 61103

John C. Troxel
222 N. Dearborn, Chicago 60601

William H. Wehrmacher
670 N. Michigan Ave., Chicago 60611

SAMA REPRESENTATIVE
Mark Larsen
710 N. Lake Shore Drive, Chicago 60611
STAFF: H. Michael Wild

Responsibilities and Purposes:

The Committee on Alcoholism serves as an ISMS resource on alcoholism and evaluates information and makes recommendations to the Board of Trustees for the position ISMS should take on issues in this area. It cooperates with institutions, industry, government and health agencies in disseminating information on the causes, prevention, diagnosis, and treatment of alcoholism to the medical profession and the public.

COMMITTEE ON ALLIED HEALTH EDUCATION
(Council on Education and Manpower)

Richard M. Magraw, *Chairman*
1853 W. Polk St., Chicago 60612

Lawrence L. Hirsch, *Vice-Chairman*
834 West Wellington, Chicago 60657

James D. Eggers

Carl Neuhoff
530 N. E. Glen Oak Ave., Peoria 61603

William Stewart
326 N. 7th, Springfield 62701

Peter C. Altner
290 Lee Road, Northbrook 60062

SAMA REPRESENTATIVES
Kevin Paulsen
818 S. Wolcott, Chicago 60612

CONSULTANTS
Eugene P. Johnson
22 W. Main St., Casey 62420
STAFF: H. Michael Wild

Responsibilities and Purposes:

As a means to alleviate the effects of a physician shortage that exists in virtually all parts of Illinois, it has been suggested that allied health personnel be educated and trained to perform certain medical procedures heretofore done only by physicians. This committee should be concerned with the specific types of medical procedures which could be done readily by trained non-physicians and what education and training is needed to qualify such individuals as "assistant physicians." The committee necessarily will concern itself with the legality of this activity under the Illinois Medical Practice Act, the implications of licensure and relations with the Illinois Department of Registration and Education, and liaison with medical schools and other educational institutions established for training of the personnel involved.

COMMITTEE ON BENEVOLENCE
Sub-Committee of Finance Committee
(Board of Trustees)

Keith H. Frankhauser, *Chairman*
Washington Street, Avon 61415
Allison L. Burdick, Sr.
5906 West North Avenue, Chicago 60639
Leo P. A. Sweeney
10400 South Western Avenue, Chicago 60643
AUXILIARY REPRESENTATIVE
Mrs. Lloyd Teter
335 Country Club Drive, Pekin 61554
STAFF: Perry Smithers

Responsibilities and Purposes:

The Medical Benevolence Committee shall be a subcommittee of the Finance Committee and shall:
1) Examine applications to the Society for assistance to determine eligibility for assistance.
2) Keep the names of the beneficiaries confidential and known only to the committee.
3) Recommend to the Finance Committee the allotment for each recipient, and
4) If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next bud get appropriation.

COMMITTEE ON CHILD HEALTH
(Council on Environmental and Community Health)

Ralph H. Kunstadter, *Chairman*
664 N. Michigan Ave., Chicago 60611
Irving Abrams
2800 Lake Shore Dr., Chicago 60657
Samuel Adler
913 Ottawa Dr., Dixon 61021
Richard E. Dukes
Carle Clinic, Urbana 61801
W. W. Fullerton
101 N. Market St., Sparta 62286
Edmond R. Hess
1737 W. Howard St., Chicago 60626
Eduard Jung
13826 Lincoln Ave., Dolton 60419
Franklin Munsey
1429 Myott Ave., Rockford 61101
Kenneth S. Nolan
172 Schiller, Elmhurst 60216
T. A. Palus
101 Orchard Terrace, Lombard 60148
Norman T. Welford
656 58th St., Hinsdale 60521
Lawrence Breslow
1500 Shermer Road, Northbrook 60062
CONSULTANT
J. Keller Mack
922 S. 4th, Springfield 62702
SAMA REPRESENTATIVE
Patricia Dix
2910 Logan Blvd., Chicago 60647
AUXILIARY REPRESENTATIVE
Mrs. Wendell Roller
309 S. Main, Monmouth 61462
STAFF: H. Michael Wild

Responsibilities and Purposes:

The committee shall serve as a source of information on matters pertaining to child health. It shall evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area and cooperate with institutions and voluntary health agencies in disseminating information pertinent to general child health. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public. It shall conduct educational programs for public enlightenment for the encouragement and the establishment of school health councils; it shall strive for increased services for exceptional children. It shall conduct in cooperation with the Maternal Welfare Committee research on neonatal mortality through the state; and shall seek the formulation and adoption of uniform school health records.

COMMITTEE ON COMMITTEES
(Board of Trustees)

Warren W. Young, *Chairman*
3450 Haweswood Dr., Crete 60417
A. Edward Livingston
219 North Main Street, Bloomington 61701
David S. Fox
20829 Greenwood Center Court,
Olympia Fields 60461
STAFF: Perry Smithers

Responsibilities and Purposes:

The Committee on Committees shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board. The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

COMMITTEE ON CONSTITUTION & BYLAWS
(Board of Trustees)

Charles K. Wells, *Chairman*
117 North 10th Street, Mt. Vernon 62864

Fredric D. Lake, *Co-Chairman*
1041 Michigan Avenue, Evanston 60202

Arthur F. Goodyear
142 East Prairie Street, Decatur 62523

Warren W. Young
3450 Haweswood Dr., Crete 60417

CONSULTANT

Frank M. Pfeifer
Paul W. Sunderland

STAFF: Perry Smithers

Responsibilities and Purposes:

The Committee on Constitution & Bylaws shall:
1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;
2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and
3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

The Speaker of the House of Delegates shall be an ex-officio member of this committee.

COMMITTEE ON CONTINUING EDUCATION
(Council on Education and Manpower)

Herschel L. Browns, *Chairman*
4600 N. Ravenswood, Chicago 60640

Dean R. Bordeaux
2421 W. Rohmann, Peoria 61604

Kenneth W. Anderson
8501 Cottage Grove, Chicago 60619

Robert E. Fitzgerald
542 Duane, Glen Ellyn 60137

Leo R. Green
1114 Milton Road, Alton 62002

William F. Hubble
38 S. Shore Drive, Decatur 62521

Mays C. Maxwell
4202 Bond Ave., East St. Louis 62207

John C. Rathe
1505-7th St., Moline 61265

Forrest H. Riordan, III
5670 E. State St., Rockford 61108

Robert J. Shafer
404 W. Washington, Petersburg 62675

Herbert Sohn
4640 N. Marine, Chicago 60640

Gordon H. Sprague
502 Shaw Ave., Paris 61944

Jerry L. Beguelin
Irvington 62848

Sheldon Waldstein
801 Skokie Blvd., Northbrook 60062

Andrew Thomas
Suite 700, 1020 S. Wabash, Chicago 60605

SAMA REPRESENTATIVES

Kong Meng Tan
1926 W. Harrison, Chicago 60612

CONSULTANTS

George Shropshear
1525 E. 53rd St., Chicago 60615

Fred Z. White
723 N. 2nd St., Chillicothe 61523

STAFF: Richard A. Ott

Responsibilities and Purposes:

The committee is responsible for encouraging physicians of Illinois to keep abreast of medical advances by participating in various types of continuing education programs. It should be aware of the agencies offering continuing education courses, measure the value of such courses where possible and strive to coordinate them in order to prevent duplication and uncover significant gaps in types of courses available.

The committee should consider itself a monitoring arm of ISMS rather than an operational arm, except that where specific areas of continuing education are not available to Illinois physicians, it should take whatever steps are necessary to provide necessary programs.

The prime responsibility of the committee is to maintain the excellence of the profession by encouraging ISMS members to "keep up" by participating in acceptable continuing education programs.

The committee shall be responsible for operating a Scientific Speakers Bureau through which county medical societies can obtain scientific speakers for its programs.

COMMITTEE ON DRUGS AND THERAPEUTICS

Robert C. Muehrcke, *Chairman*
518 N. Austin Blvd., Oak Park 60302

Joseph D. Cece
120 Oakbrook Center, Oak Brook 60521

Charles R. Frazer, Jr.
1401 Gaty Ave., East St. Louis 62201

Richard L. Landau
950 E. 59th St., Chicago 60637

W. H. Walton
109 S. High St., Belleville 62220

CONSULTANTS

Louis Gdalman, R.Ph.
Rush-Presbyterian-St. Luke's Hospital
1753 W. Congress St., Chicago 60612

IDPA Director *(to be named)*

A. E. Livingston
219 N. Main St., Bloomington 61701
STAFF: Mrs. Pat Uznanski

Responsibilities and Purposes:

The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

EAR, NOSE AND THROAT HEALTH COMMITTEE
(Council on Governmental Affairs)

John J. Ballenger, *Chairman*
723 Elm St., Winnetka
George H. Conner
1725 West Harrison, Chicago
Paul H. Holinger
700 N. Michigan, Chicago, 60611
Richard E. Marcus
64 Old Orchard, Skokie, 60076
Guy O. Pfeiffer
213 S. 17th St., Mattoon, 61938
William A. Weiss
118 West Laurel St., Springfield, 62709
CONSULTANTS
Meyer Fox
2040 W. Wisconsin Ave., Milwaukee
Earl Harford, Ph.D., Northwestern School of Medicine,
303 E. Chicago, Chicago
Maurice Hoeltgen
1836 W. 87th St., Chicago
STAFF: Larry N. Booth

Responsibilities and Purposes

The function of the Ear Nose and Throat Health Committee is to concern itself with state legislation regarding Laryngological and Otological matters, to secure and disseminate information and make recommendations regarding specific legislative proposals. The Ear Nose and Throat Committee shall also work in connection with the Chicago Laryngological and Otological Society.

EDITORIAL BOARD
(Sub-Committee of Publications Committee)

Frederick Steigman, *Chairman*
1825 West Harrison Street, Chicago 60612
Edward DuVivier
1900 Brown Street, Alton 62007
Arthur DeBoer
720 North Michigan Ave., Chicago 60611
Joseph H. Kiefer
25 East Washington, Chicago 60602
Clarence J. Mueller
108 West 4th Street, Sterling 61081
Robert E. Lane
251 East Chicago Ave., 60611
David Shoch
303 East Chicago Ave., Chicago 60611
Newton DuPuy
1842 Grove, Quincy 62301
Thomas J. Collins
7015 South Luella Ave., Chicago 60617
Arkell M. Vaughn
9012 South Leavitt, Chicago 60643
Edward P. Cruzat
8501 S. Cottage Grove, Chicago 60619
Alan P. Winnie
2542 Greenleaf Ave., Willmette 60091
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1000 Lake Shore Plaza, Chicago 60610

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Harvey Kravitz
5830 Dempster, Morton Grove 60053
RESIDENT: Neil Allen
7135 Carol St., Niles 60648
CONSULTANT
William E. Adams
55 East Erie, Chicago 60611
STAFF: Richard A. Ott
Michaelyn Sloan

Responsibilities and Purposes

The responsibilities of this committee lie in the area of the editorial content of the *Illinois Medical Journal.* It will function as a sub-committee of the Publications Committee. It shall make recommendations to the editor concerning the scientific content, regular features and subjects of special interest to the members. It shall serve as a review board for manuscripts which the editor believes require special medical evaluation. It shall assist the editor in any way possible to obtain and present medical manuscripts of the highest quality and maximum interest to the physicians of Illinois.

EXECUTIVE COMMITTEE
(Board of Trustees)

Willard C. Scrivner, *Chairman*
Suite #2, 6600 W. Main, Belleville 62223
Joseph L. Bordenave
1665 South St. Geneva 60134
Mather Pfeiffenberger
State and Wall Sts., Alton 62002
L. T. Fruin
5 Citizen's Square, Normal 61761
J. Ernest Breed
55 East Washington St., Chicago 60602
Jacob E. Reisch
1129 South 2nd St., Springfield 62704
Frank J. Jirka, Jr.
1507 Keystone Avenue, River Forest 60305
STAFF: Roger N. White

Responsibilities and Purposes

The Executive Committee shall consist of the president, the president-elect, the chairman of the Board, the chairman of the Finance Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board provided he is still a Trustee.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

By laws. Chapter IX, Part 4, Section 2. Paragraph A.

ETHICAL RELATIONS COMMITTEE
(Board of Trustees)

William M. Lees, *Chairman*
6518 North Nokomis, Lincolnwood 60646
L. T. Fruin
5 Citizen's Square, Normal 61761
Fred Z. White
723 N. Second Street, Chillicothe 61523
Allan L. Goslin
712 N. Bloomington, Streator 61364

Responsibilities and Purposes

The responsibilities and purposes of this committee are outlined in CHAPTER XI. DISCIPLINE, Part 2 *Illinois State Medical Society Procedure.*

Section 1. Illinois State Medical Society Ethical Relations Committee. The Board of Trustees shall appoint from its members an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and By-laws of the Illinois State Medical Society or its component societies and charges of misconduct of members of the Society.

Section 2. Appeals from Component Society Verdicts. Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board of review. (Appeals must be accompanied by a comprehensive stenographic record of the proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused "not guilty"). The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. Verdict. The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial, the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. Notification and right of appeal. The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

EYE HEALTH COMMITTEE
(Council on Governmental Affairs)

Warren W. Kreft, M.D., *Chairman*
940 Lee St., Des Plaines 60016
Frederick Crowley, M.D.
1008 N. Main, Bloomington 61701
Maurice M. Hoeltgen, M.D.
1836 West 87th St., Chicago 60620
John Helm, M.D.
Weber Medical Clinic
1200 N. East St., Olney
Elwood Kortemeier, M.D.
1110 S. Park Blvd., Freeport 61032
Samuel Schall, M.D.
30 N. Michigan, Chicago 60602
Alfred G. Schultz, M.D.
237 E. State St., Jacksonville 62650
Robb Smith, M.D.
261 E. Lincoln Hwy., DeKalb 60115

STAFF: Timothy D. Selleck

Responsibilities and Purposes

The function of the Eye Health Committee is to concern itself with state legislation regarding ophthalmic matters, to secure and disseminate information and make recommendations regarding specific legislative proposals. The Eye Committee also meets with the Illinois Association of Ophthalmology to study problems and formulate policy on the medical and socio-economic aspects of ophthalmology.

FINANCE COMMITTEE
(Board of Trustees)

Mather Pfeiffenberger, *Chairman*
State & Wall Streets, Alton 62002
Jacob E. Reisch
1129 South 2nd Street, Springfield 62704
William M. Lees
6518 North Nokomis, Lincolnwood 60646
Fred Z. White
723 North Second Street, Chillicothe 61523
STAFF: Roger N. White
Sandie Koelbel

Responsibilities and Purposes

The Finance Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

COMMITTEE ON HEALTH CARE FINANCING
(Board of Trustees)

Joseph R. O'Donnell, *Chairman*
444 Park, Glen Ellyn 60137
Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest 60305
Frederick E. Weiss
15643 Lincoln, Harvey 60426
Eugene P. Johnson
P.O. Box 68, Casey 62420
George Shropshear
1525 E. 53rd. St., Chicago 60615
Joseph L. Bordenave
1665 South St., Geneva 60134
CONSULTANT
Jacob E. Reisch
1129 S. Second St., Springfield 62704
STAFF: Joseph J. Lotharius

Responsibilities and Purposes:

The Committee on Health Care Financing shall consider new concepts of health care delivery and submit recommendations to the Board on the feasibility of implementing such concepts at the county, district and or state level. The committee shall also define the usual, customary, and reasonable fee concept and assure its adherence throughout the state. In performing this function, the committee shall meet with representatives of health insurance carriers, government intermediaries and other third parties. It shall also review the adequacy and appropriateness of physician reimbursement in accordance with ISMS policies.

AD HOC COMMITTEE ON HOSPITAL RELATIONS
(Council on Social and Medical Services)

Julian Buser, *Chairman,* 4601 State St., East St. Louis 62205

Standby ad hoc committee; committee members to be appointed when needed.

COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY
(Medical-Legal Council)

Vincent Sarlev *Chairman*
682 Pine, Deerfield 60015
Dennis Dorsey
ONO25 Winfield Rd., Winfield 60190
Jerome J. McCullough
110 North High Street, Belleville 62220
Maurice D. Murfin
250 North Water St., Decatur 62523

CONSULTANTS

William Adams
55 E. Erie, Chicago 60611
Robert T. Fox
2136 Robin Crest, Glenview 60025
STAFF: H. Michael Wild

Responsibilities and Purposes:

The Committee shall cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, implement the Impartial Medical Testimony panel. The stated objective of the panel is to provide consultations, judgment and opinions in personal injury situations in which there is unusual controversy or wide divergence of medical opinion.

COMMITTEE ON INSURANCE
(Council on Public Relations & Membership Services)

Lawrence Knox, *Chairman*
600 East Main, Olney 62450
Philip D. Boren
507 W. Main, Carmi 62821
Charles B. Clayman
4640 Marine Drive, Chicago 60640
Martin Compton
3003 East Oakland Ave., Bloomington 61701
Sanford A. Franzblau
Golf Mill Professional Bldg., Niles 60648
A. Everett Joslyn
557 Keystone Ave., River Forest 60305

CONSULTANTS

A. Edward Livingston
219 North Main, Bloomington 61701
Jacob E. Reisch
1129 South 2nd Street, Springfield 62704
Fred Z. White
723 North 2nd Street, Chillicothe 61523
STAFF: Perry Smithers

Responsibilities and Purposes:

The Committee on Insurance will review society-sponsored insurance programs, which are currently the Tax Qualified Retirement Program (Keogh/Retirement Investment Program, Group Disability Program, Group Major Medical Program, Hospital Income Program and Professional Liability Insurance Program. The committee will study these plans, make suggestions for changes, additions and cancellation of policies, and investigate other insurance programs that may benefit society members.

COMMITTEE ON LABORATORY SERVICES
(Medical-Legal Council)

James Habegger, *Chairman*
32 S. Lincoln, Geneva 60134
Ronald Jessen, 350 North Wall Street, Kankakee 60901
John J. Mueller, 24 Logan Fairmont Addition, Alton 62002
Peter Soto, 211 S. Third Street, Belleville 62221
Hans Willuhn,
Jack Williams,
CONSULTANTS
Frank J. Jirka, Jr.
1507 Keystone, River Forest 60305
Joseph L. Bordenave
1665 South St., Geneva 60134
Charles K. Wells
117 N. 10th St., Mt. Vernon 62864
STAFF: H. Michael Wild

Responsibilities and Purposes

The committee shall effect methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians, and encourage each county and district to establish evaluation committees.

COMMITTEE ON LICENSURE
(Medical-Legal Council)

Ross Hutchison, *Chairman*
126 East 9th Street, Gibson City 60936
Wilson West
7300 State, East St. Louis 62203
Henry Boldt
3526 N. California, Peoria
Raymond B. Murphy
R. 3, Box 19, Robinson 62454
Morgan Meyer
815 South Main, Lombard 60148
William T. Davin
9701 West Grand Avenue, Franklin Park
Earl Klaren, 158 E. Cook Street, Libertyville 60048
Orren D. Baab
550 N. Monroe, Hinsdale 60521

CONSULTANTS
Charles K. Wells
117 N. 10th St., Mt. Vernon 62864
Joseph L. Bordenave
1665 South St., Geneva 60134
Frank J. Jirka, Jr.
1507 Keystone, River Forest 60305
STAFF: H. Michael Wild

Responsibilities and Purposes

The Committee shall concern itself with the illegal practice of medicine and other healing arts groups associated with unfounded claims for cure of disease. It shall cooperate with the legal authorities of the state, such as the office of the Attorney General and the Department of Registration and Education and concern itself with the general problems of licensure. It shall cooperate with the AMA's Department of Investigation and other agencies interested in this field.

COMMITTEE ON MATERNAL WELFARE

Robert R. Hartman, *Chairman*
1515A Walnut St., Jacksonville 62650
Frederick H. Falls, *Chairman Emeritus & Special Consultant*
Box 47, River Forest 60305
DISTRICTS

MEMBERS AND ALTERNATES
(alternates in italics)

1. William R. Larsen
13707 E. Jackson, Woodstock 60098
Gordon T. Burns
2300 N. Rockton, Rockford 61101
2. William J. Farley
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Donald M. Gallagher
Box 538, Granville 61326
3. Melvin Goodman
13826 Lincoln Ave., Dolton 60419
Charles F. Kramer
12647 S. Justine St., Calumet Park 60643
4. V. B. Adams
301 E. Jefferson, Macomb 61455
Ralph Gibson
416 St. Marks Ct., Peoria 61603
5. William W. Curtis
100 W. Miller, Springfield 62702
Robert Maletich
1025 S. 7th St., Springfield 62703
6. Robert R. Hartman
1515A Walnut St., Jacksonville 62650
Richard Yoder
601 E. 3rd, Alton 62002
7. Paul A. Raber
149 W. King, Decatur 62521
Hubert Magill
1170 E. Riverside, Decatur 62521
8. John C. Mason Jr.
715 N. Logan, Danville 61832
J. Roger Powell
602 W. University, Urbana 61801
9. Harry J. Lewis
104 S. Maple, Benton 62812
Donald R. Risley
319 Market St., Mt. Carmel 62863
10. James B. Stotlar
15 N. Walnut, Pickneyville 62274
William B. Skaggs
Doctor's Clinic, 203 N. Vine, Harrisburg 62946
11. John J. McLaughlin
2100 Glenwood, Joliet 60435
Charles P. Westfall
172 Schiller, Elmhurst 60126

CONSULTANTS
John Louis
10721 S. Hoyne, Chicago 60643

Willard C. Scrivner
Suite #2, 6600 N. Main St., Belleville 62223
August Webster
707 N. Fairbanks Ct., Chicago 60611
Franklin D. Yoder
535 W. Jefferson, Springfield 62707
STAFF: Richard A. Ott

Responsibilities and Purposes

The committee shall cooperate with the State Department of Public Health in reducing the maternal mortality rate in Illinois. As a means of achieving this goal, it shall review all maternal deaths reported and send its evaluation of the management of the case to the attending physician. Appropriate measures should be taken to share the results of this research with those practitioners in a position to apply it for the benefit of their patients.

COMMITTEE ON MEDICINE & RELIGION
(Council on Public Relations and Membership Services)

Charles W. Pfister, *Chairman*
5511 N. Harlem Ave., Chicago 60656
William B. Rich
2160 S. 1st Ave., Maywood 60153
Clement P. Cunningham
2526 18th Ave., Rock Island 61201
William H. Whiting
Box 410, 525 N. Main, Anna 62906
David J. Kweder
4 S. Genesee St., Waukegan 60085
Milton Miller
3240 W. Franklin St., Chicago
CONSULTANTS
Rev. Harold Kamenz
4440 W. 95th St., Oak Lawn 60453
Rabbi Mordecai Simon
Chicago Board of Rabbis, Suite 500
72 E. 11th Street, Chicago 60605
Father John Marren
Holy Trinity Church, 916 S. Wolcott Chicago 60612
Warren Young
3450 Haweswood Dr., Crete 60417
AUXILIARY REPRESENTATIVE
Mrs. Sherman C. Arnold
2416 Brookwood Ave., Flossmoor 60422
SAMA REPRESENTATIVE
Stefan Mokrohisky
4841 S. Woodlawn Ave., Chicago 60615
STAFF: Marian Thiele

Responsibilities and Purposes

The primary purpose of the Committee on Medicine and Religion is to assist in establishing similar committees on the county level. It is also responsible for creating closer ties between physicians and the clergy, leading to total patient care.

COMMITTEE ON NARCOTICS
(Council on Mental Health and Addiction)

Joseph H. Skom, *Chairman*
707 N. Fairbanks Court, Chicago 60611
Richard B. Eisenstein
111 N. Wabash, Chicago 60602
Kermit T. Mehlinger
4901 S. Drexel Blvd., Chicago 60615
Harry W. Parks
100 N. Euclid Ave., St. Louis 63108
George Silvest
114 E. Everett, Dixon 61021
David Slight
25 E. Washington St., Chicago 60602
Richard K. Albers
815 S. Main, Lombard 60148
AUXILIARY REPRESENTATIVE
Mrs. Leslie Lindeen
801 Stevens, Sycamore 60178
STAFF: Richard A. Ott

Responsibilities and Purposes

The functions of the Committee are: (1) study, research and dissemination of educational information on narcotics and hazardous substances to members of the medical profession; (2) to recommend acceptable measures for the control of distribution, use and disposal of narcotics and hazardous substances, exclusive of radiation products but including poison control, and (3) to cooperate with official and non-official agencies in all matters pertaining to this subject.

COMMITTEE ON NURSING
(Council on Social and Medical Services)

William A. Hutchison, *Chairman*
4753 N. Broadway, Chicago 60640
Jaroslav F. Neskodny
6820 Windsor Ave., Berwyn 60402
Charles A. McClelland
502 Shaw Ave., Paris 61944
Ross Schlich
Memorial Hospital, Springfield 62701
Robert C. Stepto
3233 S. King Dr., Chicago 60616
CONSULTANTS
Dr. Helen Grace
University of Illinois, P.O. Box 6998
Chicago 60680
Mrs. Joyce Taylor
363 E. Burlington, Riverside 60546
AUXILIARY REPRESENTATIVE
Mrs. Thomas Glatter
2407 Spring Brook Ave., Rockford 61107
STAFF: Marian Thiele

Responsibilities and Purposes

The primary purpose of the Committee on Nursing is to establish a close professional relationship between physicians and nurses and to assist in recruiting programs to help relieve the current nursing shortage. The committee will also work to improve educational programs for nurses, working relationships between physicians and nurses in hospitals, and the nurses' hospital duties, to utilize their full potential and skill.

COMMITTEE ON NUTRITION
(Council on Environmental and Community Health)

Eugene F. Diamond, *Chairman*
2160 S. 1st, Maywood 60153
Sheldon Berger
707 N. Fairbanks Ct., Rm. 1106 Chicago 60611
Allen A. Filek
Box, 870, Evanston 60204
Ben A. Kinsman
20 N. Washington, DuQuoin 62832
Alfred D. Klinger
5229 Woodlawn Ave., Chicago 60615
Philip Lynch
1314 N. Main, Decatur 62526
Rene St. Leger
3909 State St., East St. Louis 62205
John E. Walters
231 E. 75th St., Chicago 60619
Robert Mendelsohn
1210 Lake St., Evanston 60201

CONSULTANT
George Shropshear
1525 E. 53rd St., Chicago 60615
STAFF: Richard A. Ott

Responsibilities and Purposes

The committee shall serve as a source of information on nutrition matters for the ISMS and evaluate available information and make recommendations to the Board of Trustees for the position the ISMS should take on issues in this area. It shall cooperate with institutions and voluntary health agencies in disseminating information on nutrition subjects to the profession and to the public. It shall be on the alert for misleading or fallacious programs and information which need correction for the protection of the public.

COMMITTEE TO STUDY OSTEOPATHIC PROBLEMS
(Board of Trustees)

Arthur F. Goodyear, *Chairman*
142 East Prairie Street, Decatur 62523
Eugene P. Johnson
P.O. Box 68, Casey 62420
Frederick E. Weiss
15643 Lincoln, Harvey 60426
Fredric D. Lake
1041 Michigan Avenue, Evanston 60202
STAFF: Roger N. White

Responsibilities and Purposes

The responsibilities of this committee are to assist in developing rapport, cooperation with and an understanding of the osteopathic profession. The committee shall study and report on the present situation in Illinois in view of recent action by the House of Delegates which permits qualified osteopaths to be members of the Medical Society.

POLICY COMMITTEE
(Board of Trustees)

Joseph L. Bordenave
1665 South Street, Geneva 60134
William Adams
55 E. Erie, Chicago 60611
David S. Fox
20829 Greenwood Center Ct., Olympia Fields 60461
STAFF: Perry Smithers

Responsibilities and Purposes

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

COMMITTEE ON PUBLIC AFFAIRS
(Governmental Affairs Council)

John W. Ovitz Jr., *Chairman*
204 West Elm, Sycamore 60118
Herbert Sohn, *Co-Chairman*
4640 N. Marine Drive, Chicago 60640
William Ashley
6545 West 33rd Street, Berwyn 60402
William W. Boswell
2500 North Rockton, Rockford 61103
Herschel L. Browns
4600 North Ravenswood Avenue, Chicago

James E. Coeur
630 Locust Street Carthage 62321
Justin Fleischmann
320 S. Ela Road, Palatine 60067
George J. Gertz
2376 E. 71st Street, Chicago 60649
J. R. Shackelford
Medical Center Clinic of Paris, Paris 61944

William J. Hillstrom
280 Virginia Avenue, Crystal Lake 60014
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117 N. 10th St., Mt. Vernon 62864
Rocco Lobraico, Jr.
4833 Peterson, Chicago 60646
Earl V. Klaren
158 E. Cook St., Libertyville 60048
W. Robert Malony
Carbondale Clinic, Carbondale 62901
Charles Downing
1067 W. Main, Decatur 62522
James D. Rogers
120 Scott St., Joliet 62401
Stanley E. Ruzich
9944 S. Damen, Chicago 60643
James H. Geist
12 Old Orchard, Route, 5, Kankakee
John L. Savage
723 Elm St., Winnetka 60093
Julius P. Schweitzer
120 Oakbrook Mall, Oak Brook 60521
Lee Winkler
850 S. 4th, Springfield 62703
Eugene H. Siegel
103 Haven Road, Elmhurst 60126
Lorin D. Whittaker
840 Jefferson Building, Peoria 61602
Elliott Partridge
1201 Pine St., Eldorado 62930
V.P. Siegel
6600 W. Main, Belleville 62223
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2420 Spring Brook Ave., Rockford 61107
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2623 Edgemont, Rockford 61103
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1800 Third Avenue, Rock Island 61201
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15318 Center Avenue, Harvey 60426
AUXILIARY REPRESENTATIVE
Mrs. H. J. Failor
9 Litchfield Lane, Champaign 61120
Mrs. Harry Parks
25 High Forest, Belleville 62221
SAMA REPRESENTATIVES
Steven Lipnik
416 West 5th Street, Momence, Ill. 60954, 815/472-2529
STAFF: Larry N. Booth

Responsibilities and Purposes

The Public Affairs Committee is concerned with the political process as it pertains to medicine and public health. Within this broad context, appropriate education of the public is basic to continued health improvement in a free society. The electorate must make its wishes known to public officials.

The Public Affairs Committee shall strive to generate interest in the overall field of politics to enable the physician to participate effectively. Programs of public affairs orientation, political education and campaign characteristics will be undertaken to increase the effectiveness of the physician in public affairs.

COMMITTEE ON PUBLIC SAFETY
(Council on Environmental and Community Health)

James P. Campbell, *Chairman*
322 N. Blanchard St., Wheaton 60187
Edward W. Holmblad
1350 N. Lake Shore Dr., Chicago 60610
Max Klinghoffer
127 E. Vallette St., Elmhurst 60126
Julius Kowalski
436 Park Ave., E., Princeton 61356
William J. Schnute
737 N. Michigan, Chicago 60611
Peter M. Wolkonsky
1200 Lake Shore Dr., Chicago 60610
David Boyd
602 S. Cuyler, Oak Park 60306
SAMA REPRESENTATIVE
Robert Luther
833 W. Buena, Chicago 60613
AUXILIARY REPRESENTATIVE
Mrs. Wendell Freeman
1202 Belmeade, Champaign 61820
STAFF: H. Michael Wild

Responsibilities and Purposes

The Committee shall study the medical aspects of accident prevention; alert the public to seasonal health hazards; and co-operate with the Illinois Department of Public Health, the National Safety Council and similar organizations.

PUBLICATIONS COMMITTEE
(Board of Trustees—Board Committee)

Jacob E. Reisch, *Chairman*
1129 South Second Street, Springfield 62704
A. Edward Livingston
219 North Main Street, Bloomington 61701
Warren W. Young
3450 Haweswood Dr., Crete 60417
Robert T. Fox
2136 Robin Crest Lane, Glenview 60025
STAFF: Richard A. Ott

Responsibilities and Purposes

The Publications Committee shall be composed of members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the Journal. It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the Journal.

AD HOC COMMITTEE ON RADIATION
(Council on Environmental and Community Health)

Howard A. Burkhead, *Chairman*
2650 Ridge Ave., Evanston 60201
(Standby ad hoc committee; committee members to be appointed when needed.)
STAFF: H. Michael Wild

COMMITTEE ON REHABILITATION SERVICES
(Council on Social and Medical Services)

Joel Rosen, *Chairman*
401 E. Ohio Street, Chicago, 60611
John E. Finch
135 S. Kenilworth, Elmhurt, 60126
Frank B. Kelly, Jr.
122 S. Michigan Ave., Chicago, 60603
Joseph L. Koczur
10039 Turner, Evergreen Park, Chicago, 60642
John G. Meyer
413 W. Monroe, Springfield, 62704
James C. Reid
712 S. College, Greenfield, 62044
Arthur A. Rodriquez
12800 93rd Ave., Box 35, Palos Park, 60464

CONSULTANTS
Charles K. Wells
117 N. 10th, Mt. Vernon, 62864
Frank J. Jirka, Jr.
1507 Keystone, River Forest, 60305
STAFF: Maury M. Breecher

Responsibilities and Purposes

The Committee on Rehabilitation Services shall assist public and private agencies in the establishment of policies regarding rehabilitation facilities and services; including training and quality and type of services available. The committee also works closely with the Governor's Committee on Employment of the Handicapped.

ADVISORY COMMITTEE TO THE STUDENT AMERICAN MEDICAL ASSOCIATION
(Council on Education and Manpower)

T. Howard Clarke, *Chairman*
834 Wellington, Chicago 60657

Allison Burdick, Jr.
5906 W. North Ave., Chicago 60639

Nathan Iglitzen
836 W. Wellington, Chicago 60657

Clarence Walton
602 W. University Ave., Urbana 61801

Gerald M. Berkowitz
1031 Cobblestone, Northbrook 60062

Kenneth Campione
670 N. Michigan Ave., Chicago 60611

Harold Johnson
422 North 2nd, Chillicothe 61523

John Stutzman
2103 E. Washington, Bloomington 61701

SAMA REPRESENTATIVES
Ronald Ban
822 S. Miller, Chicago 60607
Donald Batts
2342 S. 59th Ct., Cicero 60650
Robert Ljundquist
710 N. Lake Shore Dr., Chicago 60611
AUXILIARY REPRESENTATIVE
Mrs. Edward J. Szewczyk
17 Oak Knoll, Belleville 62223
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee is charged with the responsibility of maintaining liaison with officers of Student AMA Chapters in Illinois; establishing programs to acquaint medical students with the principles of organized medicine; and developing programs designed to advance the purposes of both organizations.

COMMITTEE ON STUDENT LOAN FUND
(Council on Education and Manpower)

Donald Stehr, *Chairman*
102 E. Market, Havana 62644
Jack Gibbs
175 S. Main St., Canton 61520
Charles Salesman
1 Laurel Lane, Paris 61944
CONSULTANTS
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
STAFF: Perry L. Smithers

Responsibilities and Purposes

The committee shall be responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

ADVISORY COMMITTEE TO THE DIVISION OF VOCATIONAL REHABILITATION
(Council on Economics and Peer Review)

Eli Borkon, *Chairman*
8 Pinewood, Carbondale 62901
Carl E. Clark
225 Edward St., Sycamore 60178
Joseph Compton
6600 W. Main St., Belleville 62223
Harry Grant
701 N. Walnut, Springfield 62702
Brian H. Huncke
454 Pennsylvania Ave., Glen Ellyn 60137
Thaddeus S. Pierce
3340 S. Oak Park, Berwyn 60402
Aaron M. Rosenthal
1401 California, Chicago 60608
Harold A. Sofield
715 Lake, Oak Park 60301
A. Walter Wise
502 Safety Building, Rock Island 61201
CONSULTANTS
Charles K. Wells
117 N. 10th St., Mt. Vernon 62864
STAFF: Joseph Lotharius

Responsibilities and Purposes

The Advisory Committee to the Division of Vocational Rehabilitation will meet regularly with the DVR staff on matters regarding the operation of the DVR medical program. It will submit advisory decisions to DVR on medical policy in the administration of the quality, quantity and cost of the various DVR programs. The committee should also foster a good relationship with DVR and provide a continuing program of physician education to familiarize ISMS members with the DVR program.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY
(Board of Trustees)

Frank J. Jirka, Jr., *Chairman*
1507 Keystone, River Forest 60305
L. T. Fruin
5 Citizen's Square, Normal 61761
Willard C. Scrivner
Suite #2, 6600 W. Main, Belleville 62223
STAFF: Roger N. White

Responsibilities and Purposes

The committee shall consist of the president-elect as chairman, the president, the chairman of the Board. The committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

Task Forces

To consider specific activities and give full concentration of council and staff effort to a single problem, task forces will be formed. These will function until the objective has been met and will then be dissolved. Said groups will cross functions with many councils and committees and will consist of members of other councils and committees. They will report directly to the Board of Trustees.

TASK FORCE ON PHYSICIAN SHORTAGE AND SERVICES TO MEDICALLY DEPRIVED AREAS

William M. Lees, *Chairman*
6518 N. Nokomis, Lincolnwood 60646
Fred Z. White, Vice-Chairman
723 N. 2nd St., Chillicothe 61523
Arthur Appleyard
821 Mason Drive, LaGrange
Andrew Brislen
6060 Drexel, Chicago 60637
Alfred Faber
2110 Swainwood Dr., Glenview 60025
David Fox
20829 Greenwood Center Ct., Olympia Fields 60461
Robert Freeark
803 Lake, Wilmette 60091
Jack Gibbs
24-26 Main St., Canton 61520
Allan Goslin
712 N. Bloomington, Streator 61364
Eugene Hoban
6429 North Ave., Oak Park 60302
Eugene Johnson
P.O. Box 68, Casey 62420
Morgan Meyer
815 S. Main, Lombard 60148
Thomas A. Reardon
55 E. Washington, Chicago 60602
George Shropshear
1525 E. 53rd St., Chicago 60615
Donald Stehr
102 E. Market, Havana 62644
Philip G. Thomsen
13826 Lincoln Ave., Dolton 60419

Responsibilities and Purposes

The primary responsibilities of the task force are to initiate and implement programs to alleviate the physician shortage in Illinois—particularly in rural areas—and to assist in the development of projects to improve the health care of people in medically deprived areas, such as urban ghettos.

The Task Force also has the responsibility of implementing the program of the AMA Committee on Health Care of the Poor by:

- improving health care delivery to the poor;
- developing a better understanding of the specific health problems of the rural and urban poor;
- developing health education materials for the poor; and
- promoting active recruitment of the poor into health careers.

TASK FORCE ON COMPREHENSIVE HEALTH PLANNING

John Howard Kendall, *Chairman*
502 W. Palladium Drive, Joliet 60431

Thomas P. deGraffenried
1208 Sunnymeade, DeKalb 60115

Frank J. Jirka, Jr.
1507 Keystone, River Forest 60305

Philip Lynch
1314 N. Main, Decatur

E. A. Piszczek
6410 N. Leona Ave., Chicago 60646

Maynard Shapiro
7531 Stony Island Ave. Chicago 60649

Fred Z. White
723 North 2nd, Chillicothe 61523

CONSULTANTS

Thomas Harwood
4902 Tollview Dr., Rolling Meadows 60008

Clarke Mangun
AMA, 535 N. Dearborn, Chicago 60610

Clifton Reeder
734 N. Merrill, Park Ridge 60068

STAFF: James Slawny

Responsibilities and Purposes

1. To keep abreast of all developments in the State of Illinois with respect to Comprehensive Health Planning.
2. To make recommendations as to the manner in which ISMS can initiate and maintain a position of leadership in Comprehensive Health Planning.
3. To establish and maintain a close liaison with the official state agency designated to administer the law.

Other Appointments

The Board of Directors of the Educational and Scientific Foundation, and representatives of other organizations report directly to the Board of Trustees periodically as necessary.

EDUCATIONAL AND SCIENTIFIC FOUNDATION

J. Ernest Breed, *Chairman*
55 E. Washington St., Chicago 60602

Willard C. Scrivner
Suite #2, 6600 W. Main, Belleville 62223

L. T. Fruin
5 Citizen's Square, Normal 61761

Jacob E. Reisch
1129 E. 2nd St., Springfield 62704

Frank J. Jirka, Jr.
1507 Keystone, River Forest 60305

STAFF: Perry Smithers

Responsibilities and Purposes

The foundation was founded to provide an administrative agency to foster the advancement of medical science through (1) the initiation of scientific and medical research activities, (2) the collection, evaluation and dissemination of the results of research activities to the public and (3) the implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge. The charter of the foundation calls for a board of directors consisting of the following officers of the Illinois State Medical Society: Immediate Past President (as chairman), Chairman of the Board of Trustees, President, and Secretary-Treasurer.

INDEPENDENT STATEWIDE COUNCIL ON CONTINUING MEDICAL EDUCATION

Edward Cannady, *Chairman*
6600 West Main Street, Belleville, 62223

Dean R. Bordeaux
2421 West Rohmann Avenue, Peoria, 61604

Herschel Browns
4600 North Ravenswood Avenue, Chicago, 60640

Jack Gibbs
175 South Main Street, Canton, 61520

CONSULTANT: J. Ernest Breed
55 Washington, Chicago, 60602

REPRESENTATIVES

ILLINOIS ASSOCIATION OF THE PROFESSIONS (IAP)
Frank J. Jirka, Jr., 1507 Keystone, River Forest 60305
William M. Lees, 6518 North Nokomis, Lincolnwood 60646

SWANBERG FOUNDATION, QUINCY
Arkell M. Vaughn, 9012 S. Leavitt, Chicago 60620

HEALTH CAREERS COUNCIL OF ILLINOIS (HCCI)
Eugene P. Johnson, 22 West Main St., Casey 62420 (HCCI Board)
Allison Burdick, Jr., 5906 West North Avenue, Chicago 60639 (HCCI Board)
Casper Epsteen, 25 East Washington, Chicago 60602 (Del. HCCI Senate)
Carl E. Clark, 225 Edward, Sycamore 60178 (Del. HCCI Senate)

MIDWEST REGIONAL LIBRARY ASSOCIATION
William E. Adams, 55 E. Erie St., Chicago 60611

LIAISON TO ILLINOIS SOCIETY OF THE AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS
Carl E. Clark, 225 Edward St., Sycamore 60178

ILLINOIS COUNCIL OF HOME HEALTH AGENCIES
Edward W. Cannady, 4601 State Street, E. St. Louis 62205

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ISMS SERVICES

Pursuit of Obligations

PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 360 N. Michigan Ave., Chicago, and an office in Springfield at 520 S. Sixth St. Services of the Society, under the general supervision of Roger N. White, Executive Administrator, are conducted by the following divisions:

Administration; Public Relations and Membership Services; Governmental Affairs; Publications and Scientific Services; and Health Care Delivery.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action. The Administrator channels all legal inquiries and works with the General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

To provide the membership of the Society with the best professional staff services available, headquarters has been set up by divisions.

The Assistant Executive Administrator serves within this Division as a coordinator for the programs operated by other Divisions. Further coordination between the programs of the State Society and the County Medical Societies is achieved through a Field Services Representative working under the direction of the Assistant Executive Administrator.

The Society sponsored insurance programs, benevolence programs, travel tours for members, physician placement programs, student loan fund program and all activities concerning the annual meeting are handled within the Division by the Assistant to the Executive Administrator.

The accounting and business service functions of the Society are handled by the Business Manager as a part of this Division. The Division also maintains the membership records and provides a computerized central dues billing and collection center for county medical societies. The Society's accounting and membership records are handled in close coordination with the Secretary-Treasurer under policies laid down by the Finance Committee and the Board of Trustees.

GOVERNMENTAL AFFAIRS DIVISION

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically related pieces of legislation.

The ISMS Governmental Affairs Council acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legislature is either supported or opposed to protect and pro-

mote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Integrated with and designed to augment the legislative activity is the Public Affairs Program. The ISMS Public Affairs Committee, strives to alert the physician to his role in public affairs and to involve him in effective participation in public affairs in his community, state, and nation.

Other Activities

The division also staffs the committees on Eye Health, Ear, Nose and Throat Health and Forensic Medicine.

DIVISION OF HEALTH CARE DELIVERY

The Division of Health Care Delivery, formerly a part of the Public Relations Division, was given its present status because of the many important and complex socio-economic issues currently facing medicine.

A primary function of the newly formed Division is to keep ISMS members abreast of these socio-economic topics especially the many changes being proposed in the delivery of health care. The dissemination of this information is accomplished through published articles in the *Illinois Medical Journal* and *Pulse;* and the Division's regular monthly column—*Socio-Economic News*—appearing in *IMJ*. The Health Care Delivery Division also participates in conducting appropriate programs that bring pertinent socio-economic issues directly to ISMS members.

A new responsibility of the Division is to work closely with the recently established Illinois Foundation for Medical Care. The Division staffs the ISMS Committee on Health Care Financing which was given the task of studying the Foundation concept and ultimately presenting a FMC plan to the House of Delegates for approval. The Division continues to serve as liaison between ISMS and the Illinois FMC.

In addition to its Foundation activities, the Health Care Financing Committee serves as ISMS liaison to the Illinois Department of Public Aid. Department officials meet regularly with the Committee to discuss mutual problems and work out solutions.

The Division of Health Care Delivery also staffs the Council on Economics and Peer Review and the Advisory Committee to the Department of Vocational Rehabilitation (DVR). The Council's primary function is to aid and encourage the establishment of peer review mechanisms by county medical societies. A second important Council function is to serve as the state appeals body for disputed cases initially considered by county or district peer review committees.

The Advisory Committtee to DVR serves as the ISMS liaison to this state and federally subsidized program. Through this Committee ISMS has the structure for resolving problems with DVR.

Finally, the Division staffs the IDPA Medical Advisory Committee as an observer, and the Illinois Regional Medical Program's Task Force On Health Information.

DIVISION OF PUBLIC RELATIONS AND MEMBERSHIP SERVICES

The Public Relations and Membership Services Division serves both as a news outlet to the press, and as a source of information to the membership.

With increasing frequency, the division is contacted by news writers seeking information on socio-economic, as well as scientific subjects. Its counseling services on public relations and publicity are available to any county medical society.

The Division also prepares speeches and publishes pamphlets and other materials on subjects such as health care costs, malpractice prevention procedures, and other medical topics.

News Releases

A mailing list of all Illinois newspapers, radio and television stations is maintained by the division. The list is so arranged that news releases may be addressed to individual counties, and county society secretaries may avail themselves of this service.

News releases for county societies are automatically prepared by the division staff and distributed to all news outlets in the particular county whenever a county society makes use of the ISMS post-graduate education program. Other than this, the state society's staff does not prepare news releases of county society activities unless this service is specifically requested.

Health Columns for Newspapers

Currently, ISMS provides Illinois newspapers with a series of Dr. SIMS Health Tips. The health tips carry a distinctive Dr. SIMS logo, and are provided six days a week.

Another public service column, being carried by some 411 high school newspapers throughout Illinois, is entitled "Dr. SIMS Talks to Teens." It is distributed on a monthly basis.

DIVISION OF PUBLICATIONS AND SCIENTIFIC SERVICES

The Division of Publications and Scientific Services is charged with staff responsibility for a variety of activities. This is evidenced by Council and Committee assignments, to wit: Council on Education and Manpower, Council on Environmental and Community Health, Council on Mental Health and Addiction, Medical Legal Council, the Publications Committee and the Editorial Board. Under the councils listed above are 12 committees and two sub-committees. In addition, liaison is maintained with many public and voluntary organizations, on a formal basis, in order to keep abreast of current developments and to ensure representation of the Illinois State Medical Society.

Publications

Total production of all printed materials and publications, as well as their distribution, is this division's responsibility, except for distribution of items to selected specific groups. All printing and duplicating services are furnished either through an in-plant shop or outside services through competitive bidding. Modern reproduction and collating equipment allows for professional, commercial-quality production.

In addition, all mail room services are provided by this division. An addressograph and graphotype are utilized as well as a small wing mailer, folder and stuffer, and plate burning cabinets. Mailings are accomplished through computer-supplied labels and the addressograph.

Principal among the publications of the society is the official organ, the *Illinois Medical Journal*. The *Journal* is mailed monthly to all members, as well as other selected individuals, who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state, as such pertain to the practice of medicine. The editor welcomes suggestions for articles which may be of special interest to the membership. All members should consider the *IMJ* a means of communicating with fellow Illinois practitioners.

Pulse, a monthly newsletter, is another item published through this division. It and other special publications, brochures, flyers, pamphlets, letters and cards as required by the several ISMS divisions to carry forth their mission, are produced.

Advertising

Within the *Illinois Medical Journal* and for *Pulse* commercial advertising is carried. The maintenance of the records of advertisers, insertion orders, contracts, and direct communication and liaison with advertising agencies and pharmaceutical houses fall within the purview of the division. These are accomplished through an advertising department and ISMS representatives. This furnishes opportunity of presenting a product to members of ISMS through advertising in ISMS publications.

Scientific Services

As is apparent from the list of councils and committees of ISMS for which staff responsibility is assigned, there is a multiplicity of activity. Liaison is maintained with many governmental and voluntary agencies to guarantee an awareness of current activities and to have medicine's voice heard. An ongoing scheduling of meetings of ISMS' committees provides opportunity for addressing the many concerns of medical practice today. The division, in addition, attempts to have expert information available to the members.

Needs of groups affiliated with or ancillary to ISMS, insofar as reproduction or distribution services are concerned, are also handled through the division office.

THE EDUCATIONAL & SCIENTIFIC FOUNDATION

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

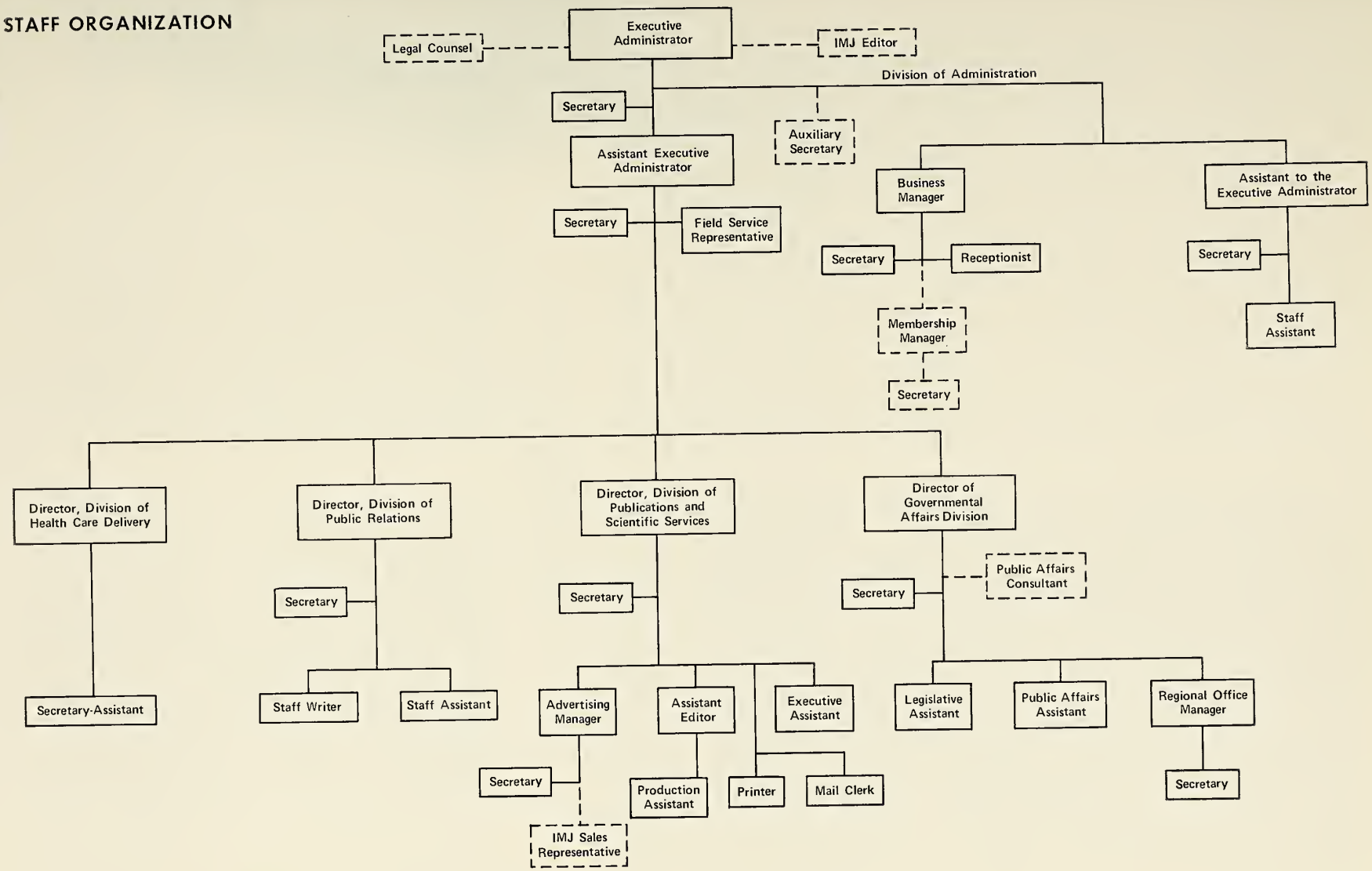
1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

STAFF ORGANIZATION



complement
32 full-time
7 part-time, retainer or contract (indicated by broken line)

FILMS

Stroke—Early Restorative Measures in Your Hospital

A film entitled "Stroke—Early Restorative Measures in Your Hospital," produced by the ISMS Committee on Aging, is available from the Society.

Directed toward physicians in all general hospitals, regardless of size, the film illustrates simple and effective methods and devices used in the rehabilitation of stroke patients. It emphasizes the procedures to be instituted immediately upon the patient's admission to the hospital.

Primary purpose of the film is to inform physicians and nurses of the need for immediate action in stroke cases and to interest them in acquiring additional details for treatment through available publications or study courses. The 20-minute sound, color film illustrates a program of constructive rehabilitation which may be conducted in any hospital, however small, by an interested nurse using a minimum of equipment.

The film may be obtained from the Society on a loan basis for viewing without charge or may be purchased for $125.

Modern Management of Multiple Births

"Modern Management of Multiple Births" is a 16 mm. sound-color motion picture produced by the Educational and Scientific Foundation of the Illinois State Medical Society in cooperation with Lederle Laboratories Division of American Cyanamid Co.

Teaching "heart" of the film is step-by-step reconstruction of an elaborate protocol which serves as a standard of prenatal planning for any physician faced with the management of multiple pregnancy.

For added teaching interest, the film reviews birth of identical quadruplets, showing how identicality was established with major and minor blood typings, examination of placenta and fetal membranes and other procedures. There are also scenes of actual delivery of quadruplets.

Showings of the film are restricted to professional audiences. Organizations may borrow the film from Lederle Laboratories Film Library, Pearl River, N. Y., or from the Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

The Time of Your Life

A 13-part, 16 mm., black-and-white sound film is available to industry, church and civic groups, fraternal organizations, and medical societies, dealing with planning and participating in a happy, secure retirement. Successfully aired over TV, the video tapes have been converted to film.

This is a self-contained educational package which provides a once-in-a-lifetime opportunity for organizations to reach people who might otherwise be deprived of vital training in retirement planning. Since about one out of every three Americans will be retired within a generation it is essential that this message be put across to obviate unnecessary wasting of human resources and economic resources among the retired.

The film is available through the Division of Public Relations, ISMS.

SPECIAL PUBLICATIONS

Pulse

Pulse is a monthly newsletter published by the Illinois State Medical Society under a grant from Roche Laboratories, Division of Hoffmann La-Roche, Inc. It is distributed to all doctors in the state, to members of the Woman's Auxiliary and Illinois Medical Assistants Association, and to interns, residents and members of SAMA.

Pulse carries non-scientific news, photographs and feature materials of interest to the medical profession in Illinois. A special section is devoted to the activities of the Woman's Auxiliary.

Comb-1 Insurance Form

Because of the variety of data required for health insurance claims, the Comb-1 Form was developed jointly by the American Medical Association and the Health Insurance Council to simplify and reduce the number of attending physicians forms equally acceptable to the health insurance industry and the medical profession.

Information requested by many diverse forms from a large number of insurance companies was first classified and minimum needs for claim purposes were determined. Then appropriate and clearly worded questions were developed and arranged in a standard sequence, to facilitate completion. Out of this came two basic forms, one for group health insurance and one for individual health insurance, and four abbreviated forms. A further simplification involved devising an all-purpose form which is a combination of the group and individual forms—the Comb-1 Simplified Health Insurance Claim Form.

These forms are available to physicians from the Illinois State Medical Society and should be substituted for any non-standardized forms received. Each physician has been asked to voluntarily adopt the following procedure:

1) When a physician receives a form from an insurance company bearing the HIC symbol it should be completed and returned to the company.

2) When a physician receives a form *not* identified by the HIC symbol, the standardized form should be filled out and clipped to the unacceptable form with both forms returned to the insurance company.

3) If the insurance company insists upon having its own form completed, the doctor should feel justified in making a reasonable charge for the added work involved in handling the non-standardized form.

The attempt to standardize these forms is an aid in cutting back on the ever-increasing load of paper work involved in medical practice. Forms are available without charge from the ISMS Division of Public Relations.

Disaster Hospital Manual

The responsibility of providing immediate medical and hospital care in disasters of any magnitude falls directly on physicians, nurses and hospitals. To aid Illinois communities in developing disaster plans, the ISMS Committee on Public Safety has adopted a model emergency plan for hospitals.

Originally developed by the Memorial Hospital of DuPage County, Elmhurst, the plan is recognized as a model by the Office of Defense Mobilization in Washington, D. C. Copies are available from the Society.

Medical Career Recruitment Programs

As man has advanced his life expectancy, it follows that many additional young men and women are and will be needed as members of the health team. Youth must be counseled early in their academic years in order to receive the proper educational background for a doctorate of medicine or allied health field degree.

The Woman's Auxiliary of the ISMS has been the spearhead force in Illinois to interest and recruit the youth of the state in medical careers. Members are asked to aid this effort by investigating the possibility of conducting or participating in career days in their home communities.

A paperback book entitled "Horizons Unlimited" is available from the Society.

Oral Contraceptive Forms

Legal consent forms for use when dispensing birth control pills are now available to ISMS members. ISMS Trustees asked that the forms be prepared and made available because of adverse court decisions against physicians prescribing the pill.

Use of the consent forms is optional with each physician.

SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances. Sponsored by the ISMS Committee on Continuing Education, the bureau helps local groups arrange and conduct postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, helping them with travel arrangements, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a $50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharp & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

The following procedures govern use of the Bureau:

1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

2) Eight weeks advance notice is required for postgraduate meetings. Requests for such meetings, which usually are scheduled for an entire afternoon, should be sent to the Scientific Speakers Bureau, Illinois State Medical Society, 360 N. Michigan Ave., Chicago.

3) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

4) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

5) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

PHYSICIANS PLACEMENT & STUDENT LOAN FUND PROGRAM

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activities. First is its own Physicians Placement Service. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

Physicians Placement Service

The Physicians Placement Service is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a resident physician.

More than 500 medical doctors have been placed through this program since its inception shortly after World War II.

The Physicians Placement Service maintains an up-to-date listing of some 255 "open" areas needing general practitioners. It maintains a similar listing of areas in need of specialists in a given field.

This service accepts requests from both physicians and communities for satisfactory placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association, the Illinois State Health Department and the Illinois Agricultural Association. Frequently, responsible citizens or overburdened physicians in a community will contact the service.

Another important function of the Physicians Placement Service is to assist small communities in developing programs to attract physicians.

The Physicians Placement Service sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics. The physician is also sent bulletins with information on new locations as they develop.

The Physicians Placement Service offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society. There is no charge either to the physician or to the community seeking the services of this program.

Illinois Medical Student Loan Fund Program

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician but lack sufficient financial resources or a recommendation for medical school.

Loans to students in need are provided by joint contributions from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans of $750 per semester—up to a total of $6,000 over a five-year period. A two per cent interest rate is charged semi-annually from the time the loan is received. The borrower must also insure himself for the entire amount of the loan and pay premiums on the policy. Repayment begins January 1 of the fifth year following medical school graduation.

The program also offers assistance to those who may not have financial difficulties but can't get into a "Class A" medical school because their college grades are marginal. The board representing the sponsoring organizations of the program can recommend candidates annually to the University of Illinois College of Medicine in Chicago. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must agree to practice medicine in an Illinois town—serving a rural population for five years. The applicant may select a town from an up-to-date list of communities which have demonstrated need and ability to support a physician, but choice is subject to approval by the program's board. The purpose of this agreement is to provide family doctors for the rural communities in Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a premedical student of at least three years college standing . . . that he take a medical college ad-

missions test, and that his college grade transcript be submitted with the completed application form. Illinois residency is not required.

The board of the Medical Student Loan Fund Program conducts its annual interview in December for those students who wish to enter medical school the following September. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, secretary, Joint Medical Student Loan Fund Board, Illinois Agricultural Association, 1701 Towanda Ave., P.O. Box 901, Bloomington.

IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of injury cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is evidence of a wide divergence of medical opinion in the injury which is subject to litigation. The introduction of the IMT examiner and subsequent examination of injuries provide the court with objective, impartial medical data for use in pre-trial conferences and in jury trials.

Authorization for the use of IMT examiners was established by the introduction of Illinois Supreme Court Rule 17-2 in September, 1961.

Illinois is distinquished in this matter by being the only state which has a court rule permitting the state-wide use of impartial medical testimony. The Illinois State Medical Society played a significant role in the creation and development of the IMT program. Impartial medical testimony in other states is limited to certain jurisdictions within the states.

The Illinois State Medical Society panel of impartial medical examiners is comprised of approximately 250 physicians who are grouped into some 20 medical specialties. Composition of the panel is reviewed annually to maintain the highest standards for the courts of Illinois.

The Illinois State Medical Society is appreciative of its role in offering, in conjunction with the Supreme Court, impartial medical service for the courts of Illinois. The IMT Committee of the state society is charged with the responsibility of maintaining the IMT panel of qualified physicians, as required by the court.

INSURANCE PROGRAMS

Retirement Investment Program

The Board of Trustees of the Illinois State Medical Society has approved the *Retirement Investment Program* which makes available to members a means of providing for retirement with group advantages an individual physician could not otherwise obtain. The Tax Qualified Retirement Program (Keogh) and the Retirement Investment Program permit balanced investments to counter economic fluctuations.

Annuities or mutual funds alone do not meet the problems of recession and inflation, but together they do permit a sound retirement plan.

The group annuity provides a guaranteed lifetime income at retirement, serving as a hedge against periods of recession or declining prices, while the mutual fund provides an opportunity for common stock investment serving as a hedge against periods of inflation or rising prices.

A member physician wishing this type of retirement protection may obtain it through the Illinois State Medical Society. By doing, so he not only receives advantages he would not otherwise have, but he is able to benefit from the collective opinions and research facilities of the insurance company and the mutual fund's investment advisor.

The *Retirement Investment Program,* making available the group annuity at a substantial reduction in premium, and the mutual funds is one of the most recent of its kind and was developed after several years of study taking into consideration other group plans and retirement alternatives.

The size of the retirement contribution, the proportion of investment between the group annuity and the mutual fund, and the retirement age are determined by the participating physician.

The National Boulevard Bank of Chicago receives all physicians' contributions, and maintains records.

Group Annuity

The group annuity, underwritten by the Continental Assurance Co., participates in dividends which are reinvested annually at compound interest.

The group annuity may provide an insurance death benefit and a total and permanent disability guarantee. In the event of death prior to retirement, a member's beneficiary would receive the death benefit or the cash value of the annuity, whichever is greater.

Six options for settlement at retirement are available under the annuity. The most frequently

chosen is the life income option which guarantees a base income for life that can never be outlived. With the increase of life expectancy, there is a danger of depleting capital during advanced years. However, the group annuity assures, at least, a base or fixed income which cannot be outlived. Of equal importance is the fact that settlement may be arranged under the group annuity to guarantee at least a return of the member's investment to his beneficiary if he elects a life income and dies shortly after retirement.

Mutual Fund

The open end mutual fund consisting primarily of common stocks is Massachusetts Investors Growth Stock Fund which is underwritten by Vance Sanders & Company of Boston. The assets of the fund are over one billion dollars. Its sister fund, Massachusetts Investors Trust, is the nation's oldest mutual fund. The Growth Fund is offered with an 8-1/2% sales charge and the Investment Adviser, Massachusetts Financial Services Inc., receives an investment advisory fee of .09% per annum. The fund is quoted daily in most major newspapers including the Wall Street Journal. Vance Sanders & Company Inc., underwrites a group of mutual funds whose net asset value exceeds 4 billion dollars.

Group Disability Program

The Illinois State Medical Society's officially approved *Group Disability Program* is available to all eligible members of ISMS up to age 70 who are regularly attending all of the usual duties of their occupation. Three different types of coverage are available under the program, with an over-70 conversion privilege.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

Provision has been made for an adjudication committee to advise the carrier on claims and other administrative problems. The adjudication committee will review the medical data and make recommendations regarding coverage which the insurance company might otherwise reject.

The program is explained in detail in a brochure which is available by writing to Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076.

Group Major Medical Expense Plan

A $25,000 *Group Major Medical Expense Plan* designed for the Illinois State Medical Society has a 20% co-insurance feature and a $500 or $1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to $50 a day and in addition up to $45 a day in an intensive care unit. It will pay $20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to $2,000 for dependents. It will also cover a congenital anomaly from the first day of birth after the effective date of the contract up to $2,000.

New members joining the Society will be allowed to enroll without evidence of insurability or a health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

The Plan is underwritten by the Commercial Insurance Co. of Newark, N.J., and is administered by Parker, Aleshire & Co., Skokie 60076. Additional information may be obtained from the Illinois State Medical Society.

Hospital Income Plan

The Hospital Income Plan, approved by the Board of Trustees March 14, 1971, is available exclusively as a benefit to ISMS members. The society derives no income from sponsorship.

The Plan pays $25 in cash (Plan A) or $50 in cash (Plan B) for each day the participant is confined to a hospital because of accident or illness for as long as one full year, up to $9,125 (Plan A) or $18,250 (Plan B) for each accident or sickness.

All active members of the society, their employees and their families are eligible for participation during enrollment periods conducted by the Administrator, Paul H. Robineson, Jr., Administrative Services, Inc., 209 S. LaSalle St., Chicago 60604.

The daily benefits are automatically doubled for all participants under age 65 for hospital confinement due to cancer or hospital confinement in an intensive care unit.

The plan pays regardless of any insurance members have, and in addition to Medicare and Social Security benefits. Benefits are paid directly to the participant and not to a doctor or hospital. Benefits are not taxable and, therefore need not be included in your tax return.

The coverage is limited to sickness which commences or accidents which occur while the insurance is in force. However, conditions pre-existing the effective date of insurance will be covered if the participant has not received treatment or medical advice during any period of 12 consecutive months ending after the effective date of insurance. After 2 years from the effective date of insurance, coverage is guaranteed regardless of any pre-existing conditions.

The plan includes these exclusions: War or act of war, service in the armed forces of any country or international authority at war, pregnancy (including childbirth or resulting complications), or intentionally self inflicted injuries, suicide or attempted suicide, whether sane or insane.

In summary, in 1971 the Hospital Income Plan was made available to the membership and was received very well. During the initial enrollment period all members regardless of age could participate. However, in future enrollment periods participation will be limited to members under age 65. Enrollment periods are anticipated every 12 to 18

months and the Administrator is advised that the next enrollment period should be conducted in the latter part of 1972.

Tax-Qualified Retirement Program

As mentioned above, the Board of Trustees has also approved the Society's *Tax-Qualified Retirement Program,* which utilizes a Continental Assurance Company Group Annuity and the Massachusetts Investors Growth Stock Fund. This program is intended for members who may find the provisions of the Keogh Act to their advantage. A liberalization, effective in 1968, which will allow contributions made by self-employed physicians to be fully deductible has made this Program more attractive to the membership. The principal provisions of the Keogh Act are as follows:

1. A self-employed physician may set aside 10% of his net income from the practice of medicine or $2,500.00 whichever is the lesser, each year for his own retirement.
2. A self-employed physician may deduct all of this amount from his income tax.
3. A self-employed physician must include all full-time employees with three or more years service under the Plan. A full-time employee is defined as an employee working twenty hours or more a week for a period of five or more months. The employee's contributions are made by the physician as a percent of salary at least equal to that percentage of net income put aside by the physician for his own retirement.
4. Funds invested under the Tax-Qualified Retirement Program accumulate tax free until distribution.

National Boulevard Bank of Chicago acts as Trustee for the Program's Annuity and Stock Fund shares and receives all physicians' contributions and maintains the Program's records.

Members who are incorporated, or are considering incorporation, may wish to receive the information pertaining to the Illinois State Medical Society IRS approved Corporate Pension and Profit Sharing Plans. This information together with the information pertaining to the ISMS Retirement Investment Program or the Keogh Act Program may be obtained by writing the Plan Administrator: Paul H. Robinson, Jr. Inc., Administrator, ISMS Retirement Programs, 209 South LaSalle Street, Chicago, Illinois 60604.

Professional Liability Program

An ISMS-Sponsored *Malpractice Liability Insurance Program* became available to members after it was approved by the Board of Trustees and the State of Illinois Insurance Department. All members may enroll in it at any time.

The Program was devised as an answer to the physician's complaints of arbitrary policy cancellations due to high risk specialty, age, abrupt increases in premium rates and headlong out of court settlements.

The underwriter of the program is Employers' Group of Insurance Companies, an 83 year old Boston firm. The administrator is Parker, Aleshire & Company, Skokie, which has served ISMS on other insurance plans since 1946.

Here are some key features of the program:

1. Coverage is available regardless of age, area in state in which member practices, or specialty.
2. ISMS directly supervises and controls the program, in conjunction with the administrator and underwriter. No policy will be declined or cancelled without just cause and a review by an ISMS designee. Any proposals for premium rate increases or other changes will be submitted to the Insurance Committee for review and acceptance. Firm steps are being taken to improve the legal climate in Illinois. No claims will be settled without the written approval of the insured. Outstanding defense counsels, expert in malpractice cases, have been retained. The legal profession has been notified that every nuisance claim will be fought. An educational program emphasizes claim prevention techniques and informs members of malpractice trends.
3. Coverage up to $1,000,000 is available.
4. Premium rates are in line with those charged by other insurers. A unique premium saving feature makes the plan especially attractive to the member engaged in corporate practice. A better legal climate will help stabilize the rates because rates will reflect the loss experience as it occurs in Illinois.

Full details and application forms may be obtained from Parker, Aleshire & Company, 9933 North Lawler Avenue, Skokie, Illinois 60076 or by calling 312-679-1000.

RADIO-TV PUBLIC SERVICE MATERIALS

Radio materials available from the Illinois State Medical Society include:

> "Today's Health Tip"—a new 30-second health message every day. Available on records (30 messages per record) which feature the voice of Dr. "SIMS." For added local appeal scripts are also available which can be read by local announcer or physician.

In addition, the Division of Public Relations maintains a radio and television speakers' bureau, which obtains physician-speakers for radio and television interview shows on request.

Doctor's Responsibility to the Press

Physicians and the press are partners in providing a line of communication between the medical profession and the public. But, the press cannot carry out its traditional responsibility in informing the public in the area of medical and patient news without the cooperation of the medical society and individual doctors. The inevitable penalty of silence by the doctors is public ignorance, misunderstanding and fear. In a democracy, public ignorance, misunderstanding and fear can be dangerous to professional freedom.

The following outline—based on a press code adopted by the Macon County Medical Society—is suggested as a pilot guide for individual physicians and county societies in Illinois.

Availability

1) The officers, committee chairmen or designated spokesmen of county medical societies shall be available at all times to mass media personnel to provide authentic information on medical subjects.

2) A list of current spokesmen shall be supplied by county societies to the executives of every newspaper, radio and television station in the county.

3) These spokesmen may be quoted by name. They should not be considered by their colleagues as self-seeking, since authoritative attribution is done in the best interests of the public and the profession. (In addition, physicians are private citizens and as such are the subjects of news stories in their social and civic activities just like any other citizen.)

Physician News

Physicians, as scientists, are encouraged to give newspaper interviews and appear on radio and television programs on medical subjects. Physicians may report on new or unusual diseases or treatments within an ethical framework. In these instances, they should, whenever possible, notify their county society publicity chairman or the Illinois State Medical Society.

Physicians may be asked to comment as individuals on politically controversial subjects (such as socialized medicine). In this event, the physician should clearly indicate that he is expressing his personal viewpoint which should not be construed as a statement of medical society policy.

A medical society officer, however, should remember that any comment he makes—whether or not intended as personal viewpoint—is generally accepted as official policy.

Patient News

As the patient's personal physician, the doctor has an obligation to respect confidences that come to him in the performance of his duty and may not release news except with the patient's consent or those authorized to speak for him. When the press learns of the illness of private patients from other sources, the physician may cooperate with the press in answering any inquiries in the interest of accuracy and to avoid embarrassment.

When news of patients is of such a nature that it automatically falls in the public domain, physicians should feel free to release information within the framework of this code.

Patient information may be given where the nature of injuries, illness or treatment is of special interest. The report of such information shall be more in the nature of scientific information, rather than an exposé of an individual affliction.

Pre-Retirement TV and Film Series

Recognizing the current "retirement revolution" in which persons are retiring earlier and living longer, the ISMS Committee on Aging recently produced a 13-part, half hour weekly television series on pre-retirement planning entitled, "The Time Of Your Life."

The series—co-sponsored through a grant from Blue Shield Plan of Illinois Medical Service—features broadcast personality Norman Ross who interviews guest authorities on such vital topics as: financial and estate planning; meeting medical expenses; where to live in retirement; how to cope with physical and emotional problems; and constructive utilization of leisure time. Initially shown on Chicago television, the series is now available for loan on 16 mm. film to industries, businesses, and other organizations throughout the state and nation as a "ready made" course of instruction.

Woman's Auxiliary To The Illinois State Medical Society

The year of 1971-72 will bring many changes to the Woman's Auxiliary to the Illinois State Medical Society. This will be the first time in its illustrious history that our year will be concluded long before many of our activities will reach fruition. However we can set goals and then with vision, enthusiasm, and concerted action can strive to attain them. Working together knowledgeably to accomplish any task promotes the worthwhile attributes of participation— interest, friendship, and dedication.

The "knowledgeable" part will result from another change. Instead of eleven district meetings and one program enrichment session we are holding four regional workshops. This is due to requests from district councilors and county presidents who are of the opinion that true workshops conducted for interested groups in their particular areas would greatly benefit each county auxiliary. Our state chairmen are in whole-hearted accord with the plans and will form the nucleus of our traveling team.

The sessions which will divulge the latest information on all phases of auxiliary activities, supply lots of good literature to take back to the counties and develop friendship through fellowship are scheduled as follows: *September 14,* at Starved Rock Lodge for districts 2, 4, 11 which includes members-at-large and the Bureau, La Salle, Lee, Livingston, Whiteside, Henry-Stark, Knox, Mercer, Peoria, Rock Island, Warren, Du Page, Kankakee, and Will-Grundy counties; *September 15,* at Champaign for districts 5, 6, 7, 8 to include members-at-large and Logan, McLean, Sangamon, Tazewell, Adams, Madison, Morgan-Scott, Christian, Macon, Marion-Clinton, Champaign, Coles Cumberland, Crawford and Vermillion counties. *September 16,* at Oakbrook for districts 1, 3, to include all the Cook County branches and Boone, De Kalb, Jo Daviess, Kane, Lake, Stephenson and Winnebago counties and for those members who could not attend the previous workshops. *November 4,* at Belle-Claire Fair Grounds for districts 9, 10.

To streamline our activities, to eliminate surplus mail and reports, to reduce the overlapping and duplication of committee work we have divided our committees into two groups: (1) Program Oriented which includes standing committees and project committees such as AMA-ERF, Health manpower, Legislation, WA/SAMA, Benevolence. These are guided by our vice president in charge of program. (2) Our Health oriented group is chaired by the vice president in charge of Community Health and it includes all the volunteer health services and health education. This structure simplifies and explains the duties of and to whom each chairman is responsible. The chairs remain the same they are merely placed under the right tables.

The change in convention dates will cause a little scrambling. Every phase of auxiliary work will have to be pushed up two months. Our board meetings will be held on September 14, following the workshop and on December 7. All county presidents reports must be submitted to our executive secretary by January 1, for inclusion in the *Delegates Handbook.* Our membership dues must be sent to our state treasurer by December 15, so a convention delegate count can be established by January 1. By July, our convention chairman had her plans, dates, and agenda organized and was ready to begin working on the intricate details to make this the best one ever.

There is one change for which we, the Board of Directors and members, are most grateful. The Illinois State Medical Society has provided us with a part time executive secretary and now we have an office of our very own equipped by the Society. Mrs. Robert Swanson has already proven her worth. She has had several years experience in working with a medical group for she was a member of the office staff at the ISMS office. To the Board of Directors and members of the Illinois State Medical Society we offer our thanks and appreciation.

The Woman's Auxiliary to the Illinois State Medical Society is a great service organization composed entirely of the wonderful wives of the finest doctors in our state. Our goal is assisting the physicians to promote better health for all the people in all the communities in Illinois using every facet available to us. Our pleasure is assisting all the doctors' wives in doing all the worthwhile things they want to do however much time or talent they have to give.

Mrs. David Kweder,
President

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9 Litchfield Lane, Champaign, 61820
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Route 2, S. Prospect Road, Champaign, 61820
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2416 Brookwood Drive, Flossmoor, 60422

PARLIAMENTARIAN

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9. Mrs. Cyril Anslinger
26 Northbrook Drive, Mt. Vernon, 62864
10. Mrs. Arthur A. Smith
206 Country Club Lane, Belleville, 62223
11. Mrs. Eugene W. Dach
64 Marquette Street, Park Forest, 60466

Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their wives. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his wife can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Congress. It cooperates, both in election efforts and in membership solicitation activities, with the American Medical Political Action Committee (AMPAC), its counterpart on the national level.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 2010, 360 N. Michigan Ave., Chicago 60601.

American Association of Medical Assistants Illinois Society

The American Association of Medical Assistants—Illinois Society—is just what the name implies—an association of medical assistants throughout the State of Illinois who have become an educational organization with objectives as follows: (a) To bring into one association all medical assistant organizations of the State of Illinois; (b) to provide an organization for those residing in Illinois counties where no medical assistants societies are organized; (c) to assist the physicians in improving medical public relations; (d) to maintain and advance the standards of professional employment and to give honest, loyal and efficient service to the medical profession and the public; (e) to meet from time to time to secure interchange of ideas.

The medical assistant associations are educational groups —not social. *We are not a union and any attempt to promote the unionization of this society or its members automatically forfeits the membership of the person or persons making such an attempt.*

The qualified medical assistant has the opportunity to pass a special board examination and thus become a "Certified Medical Assistant." This will affect directly or indirectly every physician's office. Of note is the fact that you do not have to belong to the Association to take this examination. For further information as to qualifications necessary to take the examination write to American Association of Medical Assistants, 1 E. Wacker Dr., Chicago 60601.

Local programs in the component chapters of the society are geared to the needs of that particular area. Obviously the strictly specialist areas would have entirely different problems and educational needs than the area of the general practitioner where the office is staffed by one or two medical assistants. Hence the educational programs in your area would be decided by your own medical assistants and supervised by the doctors in your own county society.

We need you, Doctor, to encourage your medical assistants to join our association. But also you could help us by assisting us in selecting the proper educational programs which in the long run would be of most benefit to you. That is our whole purpose, to become better medical assistants so we can help you to help your patients.

Medical and Paramedical Education

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School
2020 W. Ogden Ave.
Chicago, Illinois 60612

Northwestern University Medical School
303 E. Chicago Ave.
Chicago, Illinois 60611

University of Chicago Pritzker School of Medicine
950 E. 59th Street
Chicago, Illinois 60637

University of Illinois College of Medicine
1853 W. Polk Street
P.O. Box 6998
Chicago, Illinois 60680

Stritch School of Medicine—Loyola University
2160 S. First Ave.
Maywood, Illinois 60153

The following are medical schools in Illinois which are presently in the developmental stages. The names used are not necessarily correct.

Rush Medical College
Chicago, Illinois
Anticipates enrollment to begin in 1971

Southern Illinois University Medical School
Carbondale, Illinois
Anticipates enrollment to begin in 1972

APPROVED SCHOOL FOR MEDICAL RECORD TECHNICIAN

EAST PEORIA—Illinois Central College

APPROVED SCHOOL FOR MEDICAL RECORD LIBRARIANS

CHICAGO—University of Illinois at the Medical Center

APPROVED SCHOOL OF PHYSICAL THERAPY

CHICAGO—Northwestern University Medical School

APPROVED COURSE IN OCCUPATIONAL THERAPY

CHICAGO—University of Illinois-School of Associated Medical Service

APPROVED SCHOOLS OF INHALATION THERAPY

CHICAGO—Cook County Hospital, Edgewater Hospital, Northwestern University Medical Center, Rush-Presbyterian-St. Lukes Hospital, University of Chicago Hospitals
HINES—Veteran's Administration Hospital
MOLINE—Lutheran Hospital
RIVER GROVE—Triton College
ROCKFORD—St. Anthony Hospital
SPRINGFIELD—Memorial Hospital, St. John's Hospital

APPROVED SCHOOLS OF CERTIFIED LABORATORY ASSISTANTS

ALTON—Alton Memorial Hospital
ARLINGTON HEIGHTS—Northwest Community Hospital
CHICAGO—St. Elizabeth Hospital, Swedish Covenant Hospital, Veterans Administration West Side Hospital
CRYSTAL LAKE—McHenry County College
DANVILLE—St. Elizabeth Hospital
DIXON—Sauk Valley Junior College
ELGIN—Sherman Hospital
OAK PARK—Oak Park Hospital
PALOS HILLS—Moraine Valley Community College
QUINCY—Blessing Hospital

APPROVED SCHOOLS OF CYTOTECHNOLOGY

CHICAGO—Michael Reese Medical Center, Mount Sinai Medical Center, University of Chicago Hospitals and Clinics

APPROVED SCHOOLS OF MEDICAL TECHNOLOGY

AURORA—Copley Memorial Hospital
BELLEVILLE—St. Elizabeth Hospital
BLUE ISLAND—St. Francis Hospital
CHAMPAIGN—Burnham City Hospital
CHICAGO—Augustana Hospital, Chicago Wesley Memorial Hospital, Edgewater Hospital, Grant Hospital of Chicago, Holy Cross Hospital, Illinois Masonic Medical Center, Louis A. Weiss Memorial Hospital, Mercy Hospital and Medical Center, Michael Reese Hospital and Medical Center, Mount Sinai Hospital and Medical Center, Northwestern University Medical School, Rush-Presbyterian-St. Luke's Hospital, St. Anne's Hospital, St. Anthony's Hospital, St. Joseph Hospital, St. Mary of Nazareth Hospital, University of Illinois School of Associated Medical Sciences and Veterans Administration Research Hospital
CHICAGO HEIGHTS—St. James Hospital
DANVILLE—Lake View Memorial Hospital
DECATUR—Decatur Memorial Hospital and St. Mary's Hospital
ELK GROVE VILLAGE—St. Alexius Hospital
EVANSTON—Evanston Hospital, St. Francis Hospital
EVERGREEN PARK—Little Company of Mary Hospital
FREEPORT—Freeport Memorial Hospital
GENEVA—Community Hospital
GREAT LAKES—U.S. Naval Hospital
HARVEY—Ingalls Memorial Hospital
HINSDALE—Hinsdale Sanitarium and Hospital
JOLIET—Silver Cross Hospital, St. Joseph Hospital
MAYWOOD—Loyola University Center
OAK LAWN—Christ Community Hospital
OAK PARK—West Suburban Hospital
PARK RIDGE—Lutheran General Hospital
PEORIA—Methodist Hospital of Central Illinois and St. Francis Hospital
QUINCY—St. Mary's Hospital
ROCKFORD—Rockford Memorial Hospital, St. Anthony Hospital and Swedish-American Hospital
SPRINGFIELD—Memorial Hospital, St. John's Hospital
URBANA—Carle Foundation Hospital
WAUKEGAN—St. Therese's Hospital
WINFIELD—Central Dupage Hospital

APPROVED SCHOOL FOR NUCLEAR MEDICINE TECHNOLOGY

CHICAGO—Chicago Wesley Memorial Hospital
HINES—Veterans Administration Hospital

APPROVED SCHOOLS OF X-RAY TECHNOLOGY

ARLINGTON HTS.—Northwest Community Hospital
AURORA—Copley Memorial Hospital
St. Joseph Mercy Hospital
BLOOMINGTON—Bloomington-Normal Hospital
CENTRALIA—St. Mary's Hospital
CHAMPAIGN—Burnham City Hospital
CHICAGO—Chicago Wesley Memorial Hospital
Cook County Hospital
Edgewater Hospital
Englewood Hospital
Franklin Boulevard Community Hospital
Henrotin Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Michael Reese Hospital and Medical Center
Mt. Sinai Hospital and Medical Center
Provident Hospital
Ravenswood Hospital
Roseland Community Hospital
Rush-Presbyterian-St. Luke's Hospital
St. Anne's Hospital
St. Bernard's Hospital
St. Joseph Hospital
St. Mary of Nazareth Hospital
South Chicago Community Hospital
Sydney R. Forkosh Memorial Hospital
Woodlawn Hospital
DANVILLE—Lake View Memorial Hospital
DECATUR—Decatur Memorial Hospital
DIXON—Sauk Valley College
EAST ST. LOUIS—Centreville Township Hospital
ELGIN—St. Joseph Hospital
EVANSTON—St. Francis Hospital
Evanston Hospital
EVERGREEN PARK—Little Company of Mary Hospital
GALESBURG—Carl Sandburg College
GLEN ELLYN—College of DuPage
HINSDALE—Hinsdale Sanitarium and Hospital
JOLIET—Silver Cross Hospital
St. Joseph Hospital
KANKAKEE—St. Mary's Hospital
KEWANEE—Kewanee Public Hospital
MACOMB—McDonough District Hospital
MALTA—Kishwaukee Junior College
MOLINE—Lutheran Hospital
Moline Public Hospital
OAK PARK—West Suburban Hospital
OLNEY—Richland Memorial Hospital
PARK RIDGE—Lutheran General Hospital
PEORIA—Methodist Hospital of Central Illinois
St. Francis Hospital
QUINCY—Blessing Hospital
St. Mary Hospital
RIVER GROVE—Triton College
ROCKFORD—St. Anthony Hospital
Swedish-American Hospital
ROCK ISLAND—St. Anthony's Hospital
SKOKIE—Skokie Valley Community Hospital
SOUTH HOLLAND—Thorton Community College
SPRINGFIELD—Memorial Hospital
St. John's Hospital
URBANA—Carle Memorial Hospital
Mercy Hospital

APPROVED SCHOOLS OF NURSING

Associate Degree Nursing Program

A coeducational nursing program under the auspices of a junior college, two years in length and leading to an Associate Degree in Nursing. The curriculum consists of arts and sciences at the junior college level and nursing theory closely coordinated with nursing practice, under direction and supervision of the college faculty, in community hospitals and health facilities.

Graduates, both men and women, are prepared to give patient-centered care in staff nurse positions in hospitals, nursing homes and similar situations. They are prepared to cooperate and to share responsibility for the patient's welfare with other members of the nursing and health staff, and to develop their own skills through experience as practicing nurses.

General Entrance Requirements:

Good health.

High school graduation: with courses in biological and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units recommended).

Qualification for admission to the college and the nursing curriculum.

Cost: tuition in public supported junior colleges is low, in private colleges considerably higher. Add to this: fees, books, uniforms and maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

BELLEVILLE
Belleville Area College
Department of Nursing
2555 West Blvd. 62221

CENTRALIA
Kaskaskia College
Department of Nursing
Shattuc Road 62801

CHICAGO
Amundsen-Mayfair Junior College
Department of Nursing
4626 N. Knox Ave. 60630

Kennedy-King College
Department of Nursing
7047 S. Stewart 60621

Malcolm X. College
Department of Nursing
1757 W. Harrison 60612

CHICAGO HEIGHTS
Prairie State College
Department of Nursing
197th & Halsted 60411

Olive Harvey College
Department of Nursing
10001 S. Woodlawn 60628

CHAMPAIGN
Parkland College School of Nursing
2 Main Street 61820

CICERO
J. Sterling Morton Junior College
Department of Nursing
2500 S. Austin Blvd. 60650

DIXON
Sauk Valley College School of Nursing
River Campus, R.R. #1 61021

EAST PEORIA
Illinois Central College
Department of Nursing
Highview Road,
P. O. Box 2400 61611

ELGIN
Elgin Community College
Department of Nursing
373 E. Chicago St. 60120

GALESBURG
Carl Sandburg College
Box 1407 61401

GLEN ELLYN
College of DuPage
Department of Nursing
22nd & Lambert Road 60137

GRAYSLAKE
College of Lake County
Department of Nursing
19351 West Washington 60030

HARVEY
Thornton Community College
Department of Nursing
15th St. & Broadway 60426

JOLIET
Joliet Junior College
Route #3 Houbolt Ave. 60436

KANKAKEE
Kankakee Community College
Department of Nursing
Box 888 60901

MOLINE
Black Hawk College
Department of Nursing
6600 34th Ave. 61265

OGLESBY
Illinois Valley Community College
Department of Nursing
R.R. #1 61348

OLNEY
Olney Central College
305 N. West St. 62450

PALOS HILLS
Morraine Valley Community College
Department of Nursing
10900 S. 88th Ave. 60465

PALATINE
William Rainey Harper College
Department of Nursing
Algonquin & Roselle Roads 60067

RIVER GROVE
Triton College
Department of Nursing
2000 N. Fifth Avenue 60171

ROCKFORD
Rock Valley College 61101
Department of Nursing

SPRINGFIELD
Lincoln Land Community College
Department of Nursing
3865 Frontage Road 62703

SUGAR GROVE
Waubonsee College
Department of Nursing 60554
Harper Road, P.O. Box 508

Baccalaureate Degree Nursing Program

Usually a coeducational nursing program under the auspices of a college or university, this is generally four academic or calendar years in length. The curriculum combines general education with nursing education, leading to the Bachelor of Science Degree in Nursing. Liberal education courses, such as arts and sciences, are shared with all college students. University medical centers and other related hospital and community health agencies are utilized for nursing theory and practice.

Graduates, both men and women, are prepared for beginning nursing positions in hospitals, nursing homes and community health services, and for advancement without further formal education to positions such as "nursing team" leader or head nurse. They also have the foundations for continuing personal and professional development and for graduate study and specialization in nursing.

General Entrance Requirements:

Good health.

High school graduation: college preparatory program including biology and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units). Two years of a foreign language may be required. Meets college or university admission standards.

Cost: college or university tuition fees for nursing programs are comparable to those for other majors. Range in Illinois is from approximately $1,000 to $7,000 for tuition and fees for total program. Other expenses: books, uniforms, maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take state examination for licensure as a registered nurse ("R.N.").

BLOOMINGTON
Illinois Wesleyan University
Brokaw Collegiate School of Nursing 61701

CHICAGO
DePaul University
Department of Nursing
2323 N. Seminary 60614

Loyola University
School of Nursing
6526 N. Sheridan Rd. 60626

North Park College
Department of Nursing
5125 N. Spaulding Ave. 60625

St. Xavier College
School of Nursing
103rd & Central Park 60655

University of Illinois
College of Nursing
P.O. Box 6998
845 S. Damen 60612

DEKALB
Northern Illinois University
Department of Nursing 60115

EDWARDSVILLE
Southern Illinois University
Edwardsville Campus
Department of Nursing 62025

ELMHURST
Elmhurst College
Department of Nursing
190 Prospect Street

KANKAKEE
Olivet Nazarene College
Department of Nursing 60901

PEORIA
Bradley University
Department of Nursing 61606

Diploma (Hospital) Nursing Program

A nursing program under the auspices of a hospital or independent school of nursing, two to three years in length, and leading to a Diploma in Nursing. A college or university may provide some of the courses. The curriculum consists of theory and practice focused primarily on instruction and related clinical experience in the nursing care of patients in hospitals. Some liberal arts courses may be included.

Graduates, both men and women, have the understanding and skills necessary to organize and implement a plan of nursing that will meet the immediate needs of one or more patients and that will promote the restoration of health. They are also able to plan with associated health personnel for the care of patients, and may be responsible for the direction of other members of the nursing team.

General Entrance Requirements:

Good health.

High school graduation: Usually upper half of class, with courses in biological and physical sciences (1-2 units, one of which should be chemistry) and mathematics (1-2 units).

Satisfactory results on entrance tests and qualification for admission to the school.

Cost: $900 to $3,500; some include full maintenance.

Living Arrangements: Schools have residence facilities; many permit students to live at home if preferred.

Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

ALTON
- Alton Memorial Hospital
 Memorial Drive 62002
- St. Joseph's School
 915 E. Fifth St. 62004

AURORA
- Copley Hospital
 Lincoln & Weston 60507

BLOOMINGTON
- Mennonite Hospital
 804 N. East Main 61701

CANTON
- Graham Hospital
 210 W. Walnut St. 61520

CHICAGO
- Augustana Hospital
 427 Dickens Ave. 60614
- Chicago Wesley Memorial Hospital
 250 E. Superior St. 60611
- Cook County Hospital
 1900 W. Polk St. 60612
- Illinois Masonic Hospital
 836 Wellington Ave. 60657
- James Ward Thorne—
 Passavant Memorial Hospital
 244 East Pearson St. 60611
- Michael Reese Hospital and Medical Center
 2816 S. Ellis Ave. 60616
- Mount Sinai Hospital & Medical Center
 2730 W. 15th Place 60608
- Ravenswood Hospital & Medical Center
 1931 W. Wilson Ave. 60640
- St. Anne's Hospital
 4950 W. Thomas St. 60651
- St. Bernard's Hospital
 6344 S. Harvard Ave. 60621
- St. Mary of Nazareth Hospital
 1127 N. Oakley Blvd. 60622
- South Chicago Community Hospital
 2320 E. 93rd St. 60617

DANVILLE
- Lake View Memorial Hospital
 812 N. Logan Ave. 61832

DECATUR
- Decatur Memorial Hospital
 2300 N. Edward St. 62526

EVANSTON
- Evanston Hospital
 2645 Girard Ave. 60201
- St. Francis Hospital
 319 Ridge Ave. 60202

FREEPORT
- Freeport Memorial Hospital
 1133 W. Stephenson 61032

JACKSONVILLE
- Passavant Memorial Area Hospital
 1600 W. Walnut St. 62650

JOLIET
- St. Joseph Hospital
 333 N. Madison St. 60435

MOLINE
- Lutheran Hospital
 555 Sixth St. 61265
- Moline Public Hospital
 635 Tenth Avenue 61265

OAK LAWN
- Evangelical (Christ Community Hospital)
 4440 W. 95th St. 60453

OAK PARK
- West Suburban Hospital
 518 N. Austin Blvd. 60302

PARK RIDGE
- Lutheran General and Deaconness Hospital
 1700 Western Ave. 60068

PEORIA
- Methodist Hospital of Central Illinois
 221 N.E. Glen Oak 61603
- St. Francis Hospital
 211 Greenleaf St. 61603

QUINCY
- Blessing Hospital
 1005 Broadway 62301

ROCKFORD
Rockford Memorial Hospital
2400 N. Rockton Ave. 61103
St. Anthony Hospital
5658 E. State St. 61101
Swedish-American Hospital
1316 Charles St. 61101

ROCK ISLAND
St. Anthony Hospital
767 Thirtieth St. 61201
SPRINGFIELD
Memorial Hospital
200 N. Dodge St. 62701
St. John's Hospital
401 N. Ninth St. 62701

Practical Nursing Program

A coeducational nursing program under the auspices of public vocational education systems, hospitals or community agencies, usually one year in length. The curriculum includes nursing theory coordinated with nursing practice.

Graduates, both men and women, of programs in practical nursing are prepared for two roles: (1) under the supervision of a professional nurse or physician, they give nursing care to patients in situations relatively free of scientific complexity; (2) in a close working relationship, they assist the professional nurse in giving care to patients requiring a high degree of nursing skill and judgment.

Entrance Requirements:

Good health.
High school: Two years minimum, graduation desirable. Junior and senior students who are currently enrolled in high school are eligible to enroll in the practical nursing program as part of their credit curriculum.
Satisfactory results on entrance tests.
References and personal interview.

Cost: None under MDTA programs, to approximately $400 plus maintenance.

Living Arrangements: Students usually live at home or in housing approved by school.

Graduate is eligible to take the state examination for licensure as a practical nurse ("L.P.N.").

ALTON
F. W. Olin School of Practical Nursing
2512 Amelia Street 62002
BLOOMINGTON
Bloomington School of Practical Nursing
709 S. Clinton St. 61701
CANTON
Spoon River School of Practical Nursing
CARBONDALE
Southern Illinois University Vocational Technical Institute of Practical Nursing 62901
CHAMPAIGN
Champaign School of Practical Nursing
103 N. Prospect Ave. 61821
CHICAGO
Chicago Public Schools Practical Nursing Center
1820 W. Grenshaw 60612
Chicago Public Schools Licensed Practical Nurses Program, Manpower Division
2913 N. Commonwealth 60657
St. Frances X. Cabrini School of Practical Nursing
811 S. Lytle St. 60607
DANVILLE
Danville School of Practical Nursing
200 E. Main 61832
DECATUR
Decatur School of Practical Nursing
210 W. North St. 62521
DE KALB
Kishwaukee School of Practical Nursing
612 Haish Blvd. 60115
DIXON
Sauk Valley College
River Campus Route #1 61021
EAST PEORIA
Illinois Central College Practical Nursing Program, Health Education
P.O. Box 2400 61611
EAST ST. LOUIS
School of Practical Nursing
910 Summit 62201
GALESBURG
Carl Sandburg College, Department of Practical Nursing
Box 1407, South Lake Storey Road 61401
GRAYSLAKE
Lake County College Practical Nurse Program
19315 Washington Street 60030
HARRISBURG
Southeastern Illinois College, School of Practical Nursing
333 W. Church St. 62946
HARVEY
Thornton Community College, Department of Practical Nursing
150th Broadway 60426
HINSDALE
Hinsdale Hospital School of Practical Nursing
120 N. Oak St. 60521
JACKSONVILLE
Jacksonville Board of Education School of Practical Nursing
504 E. Court St. 62650

JOLIET
Joliet Township H.S. School of Practical Nursing
201 E. Jefferson St. 60432

KANKAKEE
Kankakee School of Practical Nursing
Kankakee Community College
Box 888 60901

LASALLE
St. Mary's Hospital School of Practical Nursing
1015 O'Connor St. 61301

MATTOON
Lake Land College
School of Practical Nursing
1921 Richmond 61938

MOLINE
Black Hawk College Practical Nursing Program
6600-34th Ave. 61265

MORTON GROVE
Oakton Community College
7900 N. Nagle 60053

MT. CARMEL
Wabash Valley College Practical Nursing Program
2200 College Dr. 63863

MT. VERNON
Rend Lake College Practical Nursing Program
315 South 7th 62883

PALATINE
William Rainey Harper Practical Nurse Program
Algonquin & Roselle Roads 60067

QUINCY
Quincy School of Practical Nursing
820 Vermont Street 62301

RIVER GROVE
Triton Junior College, Practical Nursing Program
2000 N. Fifth Ave. 60171

ROCKFORD
Rockford School of Practical Nursing
201 S. Madison 61101

SPRINGFIELD
Springfield School of Practical Nursing
1101 S. 15th St. 62704

STREATOR
Streator Township High School
Practical Nurse Program
600 N. Jefferson 61364

ULLIN
Shawnee Community College
Department of Nursing
Shawnee College Road 62992

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 59 Legislative Districts. Each district elects one senator and three representatives. Thus, the Senate has 59 members and the House 177. The senators are elected for four-year terms, and the representatives serve two-year terms.

The General Assembly convenes in January of each year. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. All of these officials are elected for four-year terms.

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading when it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he will sign it. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The Governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

NOTE

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 520 S. Sixth St., Springfield, 62701.

STATE OFFICERS

Governor, RICHARD B. OGILVIE, Rep., Chicago
Lieutenant Governor, PAUL M. SIMON, Dem., Troy
Secretary of State, JOHN LEWIS, Rep., Marshall
Auditor of Public Accounts, MICHAEL J. HOWLETT, Dem., Chicago
State Treasurer, ALAN DIXON, Dem., Belleville
Attorney General, WILLIAM J. SCOTT, Rep., Evanston
Superintendent of Public Instruction, MICHAEL BAKALIS, Dem., DeKalb
Clerk of the Supreme Court, JUSTIN TAFT, Rep., Rochester

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Director's Office

524 South Second St., Springfield
Room 1713, 160 N. LaSalle St., Chicago
Edward T. Weaver, *Director*
Roman L. Haremski, Deputy Director, Program Services
Charles H. Sweeney, Deputy Director, Management Services
J. Keller Mack, M.D., Medical and Public Health Officer
Philip D. Wynn, Technical Advisor
Richard S. Laymon, Administrative Asst. to the Director and Guardianship Administrator
Thomas A. Nickell, Administrative Asst. to the Director

Office of Community Relations

524 South Second St., Springfield
Donald H. Schlosser, Administrator

Office of Planning and Community Development

524 South Second St., Springfield
William H. Ireland, Director of Planning
Thomas Villiger, Administrator of Community Development

Division of Child Welfare

524 South Second St., Springfield
Richard J. Bond, Director
Merle Springer, Director, Metropolitan Area
Ralph L. Hanebutt, Director, Downstate Area

Regional and District Offices—

Aurora Operations (Leland Wright, Dir.), 361 Old Indian Trail
Aurora District, 361 Old Indian Trail
Joliet District, Rm. 309, 57 W. Jefferson St.
Kankakee District, Rm. 300, 70 Meadowview Center
Waukegan District, 4 S. Genesee St.
Chicago Operations (Ralph Baur, Assoc. Dir., Metropolitan Area), Rm. 312, 1439 S. Michigan Ave.
Central District, 1026 S. Damen Ave.
East District, 2030 S. Michigan Ave.
North District, 4320 W. Montrose Ave.
South District, 9718 S. Halstead St.
Special Services District, 2030 S. Michigan Ave.
Herrick House Children's Center (Harvey Plaschke, Administrator), W. Bartlett Rd., Bartlett
Lawndale Day Care Center (Ben Robinson, Administrator), 2929 W. 19th St., Chicago
Woodlawn Early Childhood Development Center (Laura Tartt, Administrator), 950 E. 61st St., Chicago
Champaign Region (Thomas L. Tucker, Reg. Dir.), 2125 S. First St.
Champaign District, 2125 S. First St.
Bloomington District, 309 W. Market St.
Danville District, (temporary location 2125 S. First St., Champaign)
Decatur District, 125 N. Franklin St.
Mattoon District, 1000 Broadway
Paris Office, 327 N. Main St.
East St. Louis Region (Jack M. Donahue, Reg. Dir.), 310 N. Tenth St.
East St. Louis District, 917 Illinois Ave.
Edwardsville District, 116 Hillsboro Ave.
Murphysboro Region (E. Paul Nelson, Reg. Dir.), 9 S. 12th St.
Murphysboro District, 21 N. 11th St.
Cairo Office, 529 Cross St.
Marion District, 112A S. Market St.
Harrisburg Office, 10 S. Vine St.
Metropolis Office, City National Bank Bldg., PO Box 757
Olney District, 1108 S. West St.
Salem District, 205 E. Locust St.
Southern Illinois Children's Service Center (James W. DeLeonardis, Administrator), Hurst
Peoria Region (Francis R. Paule, Reg. Dir.), 5415 N. University Ave.
Peoria District, 5415 N. University Ave.
Galesburg District, 121 S. Prairie St.
Moline District, 1805 Seventh St.
Ottawa District, 412 W. Madison St.
Rockford Region (Margaret M. Kennedy, Reg. Dir.), 4302 N. Main St., P.O. Box 915
Rockford District, 4302 N. Main St., P.O. Box 915
Rock Falls District, 203½ First Ave.
Springfield Region (William W. Sanders, Reg. Dir.), Rm. 122, 4500 S. Sixth St. Rd.
Springfield District, Rm. 122, 4500 S. Sixth St. Rd.
Carlinville District, 494½ W. Side Square
Jacksonville District, 602 Westgate Ave.
Quincy District, 410 N. Ninth St.

Division of Education and Rehabilitation Services

524 South Second St., Springfield
Lee A. Iverson, Director

Institutions—

Illinois Braille and Sight Saving School (Jack Hartong, Supt.), Jacksonville
Illinois Children's Hospital-School (Paul Kavanaugh, Supt.), 1950 W. Roosevelt Rd., Chicago
Illinois School for the Deaf (Kenneth Mangan, Supt.), Jacksonville
Illinois Soldiers' and Sailors' Children's School (Andrew Spelios, Supt.), Normal
Illinois Soldiers' and Sailors' Home (Richard Northern, Supt.), Quincy
Illinois Visually Handicapped Institute (Thomas Murphy, Supt.), 1151 S. Wood St., Chicago

Visually Handicapped Services—

Community Services for the Visually Handicapped (I. N. Miller, Supt.), Rm. 1700, 160 N. LaSalle St., Chicago
Except for Cook County, field offices for this program are located in the Department's regional offices. See listings under Division of Child Welfare.
Raymond M. Dickinson, Coordinator of Visually Handicapped Services
524 South Second St., Springfield

Division of Financial Management

524 South Second St., Springfield
Matthew J. Finnell, Chief

Division of Systems and Data Processing

524 South Second St., Springfield
August G. Egger, Jr., Chief

Division of Personnel Administration

524 South Second St., Springfield
David E. Knox, Chief Personnel Officer

DEPARTMENT OF MENTAL HEALTH

401 S. Spring St., Springfield, 62706
160 N. La Salle St., Chicago, 60601

Office of the Director

Albert J. Glass, M.D., *Director*
Philip W. Rathbun, Special Projects Advisor
Victoria Smaller, Administrative Assistant
Margaret B. Holloway, Administrative Assistant
Daniel Gallagher, Administrative Assistant
John O'Leary, Technical Advisor
Robert E. Lanier, Special Assistant
Ralph Collins, Special Assistant
Margaret Diamond, Special Assistant
Jane Phillips, Special Assistant
Natalie Seltzer, Special Assistant

Research Development and Training

Peter K. Levison, Ph.D., Manager, Research and Development
Louis Aarons, Ph.D., Research and Development Executive

Division of Legislative Liaison

H. Dickson Buckley, Manager

Division of Legal Services

Jerome Goldberg, Manager
Joan Matlaw, Chief, Legal Staff
Muriel Lotsman, Chief, Interstate Services
Ronald Olson, Chief, Claims Services
Margaret Munn, Chief, Hearings and Appeals

Division of Operation Research

Andrew L. Bavas, Manager

Management Group

Charles R. Crawford, Administrator

Division of Financial Management

Carlton Jencks, Manager
C. Balthazor, Chief, Budgetary Services
Frank Campbell, Chief, Grants
George Skadden, Chief, Audits
Ron Allen, Chief, Analysis and Evaluation
Jos. McGrath, Chief, Plant Operations
M. F. Burkhardt, Chief, Reimbursement Services

Division of Community Relations

Richard Burkland, Manager
I. D. Cravens, Chief, Public Interest Groups
Bernard McLaughlin, Chief, Professional and Educational Facilities
Norman Hufford, Coordinator, Aftercare

Division of Information Systems

Stephen Andersen, Manager
James Morris, Chief, Systems Development
George Tinsley, Chief, Production Systems
Joseph Buckles, Chief, Procedures

Field Division, Mental Health, Department of Personnel

John Meyer, Chief Personnel Officer

Special Programs

Drug Abuse Programs
Edward C. Senay, M.D., Director
Alcoholism Programs
James T. Griffin, Advisor
Physical Education, Activity and Recreation
L. Hopkins, Advisor
Children's Programs
Gerald Kissin, Ph.D., Advisor
Facilities and Program Standardization
Joseph Saxl, Advisor
Communications
Albert Heimlich, Advisor

Zones and Institutions

ROCKFORD: Donald W. Hart, Administrator, H. Douglas Singer
Zone Center, 4402 N. Main St., Rockford 61103

H. DOUGLAS SINGER ZONE CENTER: William G. Smith, M.D., Superintendent.

CHICAGO AREA ZONE: Patrick Staunton, M.D., Administrator, 232 E. Ohio St., Chicago 60611

CHICAGO/READ MENTAL HEALTH CENTER: John Nelson, M.D., Superintendent, 6500 W. Irving Park Rd., Chicago 60634

JOHN J. MADDEN ZONE CENTER: Robert deVito, M.D., Superintendent, 1200 S. First Ave., Hines 60141

ELGIN STATE HOSPITAL: Daniel A. Manelli, M.D., Superintendent, Elgin 60120

MANTENO STATE HOSPITAL: John R. Collier, Superintendent, Manteno 60950

TINLEY PARK MENTAL HEALTH CENTER: H. C. Piepenbrink, Superintendent, Tinley Park 60477

PEORIA: James Ward, M.D., Administrator, George A. Zeller Zone Center, Peoria 61614 (address mail to Galesburg State Research Hospital, Galesburg 61401)

GEORGE A. ZELLER ZONE CENTER: James Ward, M.D., Superintendent, 5407 N. University, Peoria 61614

EAST MOLINE STATE HOSPITAL: Konstantin Dimitri, M.D., Superintendent, East Moline 61244

GALESBURG STATE RESEARCH HOSPITAL: Angelo Zocchi, M.D., Acting Superintendent, Galesburg 61401

PEORIA STATE HOSPITAL: Henry D. Staras, M.D., Superintendent, Peoria 61607

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DEPARTMENT OF REGISTRATION AND EDUCATION

William H. Robinson, *Director*
Allen M. Andreasen, *Assistant Director*
Edward Price, *Coordinator,*
Division of Professional Supervision

The department is primarily concerned with the registration, licensing and enforcement of 32 laws governing the different professions, trades and occupations, including the Medical Practice Act. Enforcement of the Medical Practice Act is in the Division of Professional Supervision headed by a coordinator. Registration and licensing is under the jurisdiction of the Division of Registration.

The Medical Examining Committee appointed by the director of the department operates within the framework of the act and is charged with the responsibility of giving examinations for licensure, hearing complaints for revocation and suspension of licenses and promulgating rules and regulations for the administration of the act.

Medical Examining Committee

Eugene Hoffmann, D.C.
William G. McCarthy, M.D.
Dale E. Richardson, D.O.
S. David Ross, M.D.
Kenneth H. Schnepp, M.D.
Nat Smith, M.D.
Warren D. Tuttle, M.D.

Medical Practice Act

Licensing and Enforcement Procedures

Illinois statutes provide for licensing of physicians to practice medicine "(1) in all of its branches, and (2) licensing of those persons to treat human ailments without the use of drugs or medicine and without operative surgery."

The Medical Practice Act states, "no person shall practice medicine, or any of its branches, or midwifery, or any system or method of treating human ailments without the use of drugs or medicines and without operative surgery, without a valid existing license so to do." Applicant for license must pass an examination of his qualifications which must be satisfactory to the Department of Registration and Education.

This Act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the U.S. or the District of Columbia who has applied in writing to the Department, for a license to practice medicine and has complied with all of the necessary provisions, except the passing of an examination which may be given, except under certain conditions, i.e. withdrawal of the application, failure to pass an exam within six months, etc.

Required Education

Minimum standards of professional education: 2 years' course of instruction in a college of liberal arts or its equivalent, or in such medical colleges and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months and in addition thereto, a course of clinical training of not less than 12 months in a hospital. The college of liberal arts, medical school, and hospital must be reputable and in good standing in the judgment of the Department of Registration and Education. The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the cast of programs involving students with advanced standing.

All examinations provided for by the Medical Practice Act shall be conducted by the Department of R&E. Examinations of applicants who seek to practice medicine in all of its branches shall embrace the subjects of which knowledge is generally required of candidates for the degree of Doctor of Medicine by reputable medical colleges in the U.S., and shall be such in the judgment of the Department of R&E that as will determine the qualifications of applicants to practice medicine in all of its branches.

Every license issued under the Act expires on July 1 of each even-numbered year. Every licensee under the Act may, biennially during the month of June of each even-numbered year, renew his

license upon paying to the Department a renewal fee of $10.

Revocation and Suspension of License or Certificate

The Department may revoke, or suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license; certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or state hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon the following grounds:

"1. Conviction of procuring or attempting or aiding to procure such an abortion as was made unlawful at the time under the Criminal Code of this State;
2. Conviction in this or another state of any crime which is a felony under the laws of this state or conviction of a felony in a federal court.
3. Gross malpractice resulting in permanent injury or death of a patient;
4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;
5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;
6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties;
7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;
8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules and regulations of the department governing examinations;
9. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill or the efficacy or value of one's medicine, treatment or remedy therefor;
10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;
11. Revocation or suspension of a medical license in a sister state.
12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;
13. Except as otherwise provided in Section 16.01, advertising or soliciting by himself or through another, by means of hand bills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business."
14. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this Subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act" as now or hereafter amended or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of two or more persons holding valid and current license under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divide a fee; provided, the patient has full knowledge of the division, and, provided, that the division is made in proportion to the services performed and responsibility assumed by each.

Section 16.01. Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone number, residence address and phone number and

any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business; absence from, or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories, or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type.

Rules and Regulations Adopted for the Administration of the Illinois Medical Practice Act, Effective March 18, 1955

RULE 1—ACCREDITED COLLEGES OF MEDICINE AND SURGERY

Medical colleges having rules and curricula commensurate with and equivalent to the rules and curricula of the College of Medicine of the University of Illinois, will be considered for accreditation by the Department of Registration and Education.

RULE II—ACCREDITED COLLEGES TEACHING SYSTEMS OF TREATING HUMAN AILMENTS WITHOUT THE USE OF DRUGS OR MEDICINE AND WITHOUT OPERATIVE SURGERY.

A professional college or institution teaching a system of treating human ailments without the use of drugs or medicine and without operative surgery shall be deemed reputable and in good standing in the judgment of the Department upon submission of proof of the following requirements:

(a) That a Dean or other Executive Officer, employed on a full-time basis supervises the students and curriculum.

(b) That the faculty is comprised of graduates in their specialty from recognized professional colleges or institutions.

(c) That the faculty is organized and each department has a director, professors, associate professors and assistant professors, each responsible to his superior for his instruction in the particular subject he teaches.

(d) That, annually, a catalogue or brochure is published setting forth the requisites for admission to the college, tuition rates, courses offered, dates of sessions, schedule of classes, requirements for graduation, a roster of the undergraduate students and a roster of the last graduating class. The catalogue or brochure shall contain a list of the departments of the school, the titles of the personnel and a brief summary of each person's qualifications. The curriculum shall include, but not be limited to, four academic years' instruction in the following subjects:

(1) Anatomy
 (a) Embryology; (b) Histology; (c) Neuroanatomy
(2) Physiology and Chemistry
(3) Pathology and Bacteriology
(4) Diagnosis
 (a) Physical; (b) Differential; (c) Laboratory

(e) That suitable buildings provided with laboratories equipped for instruction in anatomy, chemistry, physiology, bacteriology and other areas of learning necessary to the due course of study prescribed by these rules; and that a laboratory equipped with supplies, models, manikins, charts, stereopticon, roentgen-ray and other special apparatus used in teaching the system to treat human ailments without the use of medicine and operative surgery, be provided.

(f) That a working library, easily accessible to students, is maintained from at least 9 a.m. to 5 p.m., with a librarian in constant attendance. The library shall contain a standard medical dictionary, the modern text and reference books, and the files of leading periodicals dealing with the particular system of treating human ailments without the use of medicine and operative surgery.

(g) That the college or institution requires all students to furnish, before matriculation, satisfactory proof of the preliminary education required by the Medical Practice Act.

(h) That full and complete records are kept showing the credentials for admission, attendance, grades and financial accounts of each student.

(i) That admission of transfer students will be limited to honorably dismissed students from another approved college or institution teaching the same system. The transcript of record obtained directly from the transferring school shall be kept on file. It shall be the duty of a college or institution to furnish such a transcript for the benefit of each student subject to honorable dismissal. No credit shall be given a transferred student for final or "senior year" work or for any courses taken by correspondence.

(j) That students shall start class attendance within one week of the start of each session. That credit for completion of a course will not be granted a student who failed to attend 80 per cent of the complete session of the course.

RULE III—HOSPITALS APPROVED FOR INTERNSHIP.

1. A hospital shall, in the judgment of the Department be deemed reputable and in good standing for training interns and intern services when it meets the following standards:

(a) General hospital of 150 beds' capacity, with an average of at least 60 patients daily, with rotating service.

(b) Shall contain at least the departments of internal medicine, surgery, obstetrics and pediatrics; and an organized departmentalized staff, holding meetings monthly for case reviews and study.

(c) Laboratory employing a full-time qualified technician and at least a part-time qualified pathologist, visiting the laboratory at least two days per week.

(d) Radiological department employing a qualified X-ray technician and at least a part-time qualified roentgenologist, visiting the department at least two days per week.

(e) Maintenance of an up-to-date medical library located in a suitable study room available to interns.

(f) Such hospital shall provide and furnish the Department with the names of staff members of the various departments of the hospital.

(g) The hospital, upon the completion of a course of training therein of not less than twelve months, shall issue its certificate therefor to any such intern or at the request of the Department, such certificate shall include therein, by date, the commencement and the conclusion thereof.

2. An approved internship shall consist of twelve months rotating service in medicine, surgery, obstetrics and pediatrics, with an election in medical specialties.

In the event an applicant has received training in excess of the twelve months' period specified by the Medical Practice Act, and if this be in an institution approved by the Department as adequate for specialty training; and if the applicant has received certification by a recognized Medical Specialty Board, and has had two or more years' specialty practice or Military Service; such training and practice may be accepted as the equivalent of a rotating internship.

Any applicant who shall have completed twelve months of clinical training in a hospital, as required by Section 5-1(b) of the Medical Practice Act, and who has been accepted for further training in a specialty or general practice residency program by a hospital or institution approved by the Department for that purpose, shall be deemed to have complied with the requirements of this rule and of the Medical Practice Act in this regard.

Rule IV—Application for Examination

An applicant for examination for licensure to practice medicine in all of its branches, or any system of treating human ailments without the use of drugs or medicine and without operative surgery, must make application on forms furnished by the Department at least fifteen days prior to the examination and present, in addition:

(a) Recommendations from two (2) physicians duly licensed to practice in some state in the United States.

(b) A recent photograph, passport size, signed by applicant and two persons licensed to practice the system of treatment of human ailments for which the applicant is seeking a license. A duplicate photograph must be presented with the card of admission at the examination.

(c) The original diploma of graduation from the professional college in which the applicant completed his course of training, or, in lieu of presenting the diploma with the application, the applicant may present it at the examination.

(d) A certified copy of secondary school and professional school studies to be mailed direct to the Department by the schools attended or by the professional schools where the applicant completed the required course of study.

(e) Proof of completion of a rotating internship of twelve months in an approved hospital for applicants seeking admission to examination for license to practice medicine in all of its branches; and, in the case of graduates of medical colleges in countries other than the United States and Canada, who apply for examination after January 1, 1953, proof of rotating internships of one year in approved hospitals in the United States.

A candidate under Section 5, paragraph Ib or Section 13, may apply for the examination or clinical test and take the examination given immediately prior to completion of his internship provided he furnishes a statement from the hospital authorities stating his internship has been satisfactory to date. The results of the examination will be withheld and no license will be issued until the Department receives proof of satisfactory completion of the required internship in an approved hospital training program.

(f) Applicants who completed their medical courses in the extramural colleges of Ireland and Scotland shall not be eligible for admission to examinations for licensure under the Illinois Medical Practice Act.

(g) Graduates of European medical colleges or universities after January 1, 1943, with the exception of certain approved colleges in the British Isles, Denmark, Holland, Norway, Sweden and Switzerland, be not accepted for admission to examinations for licensure under the Illinois Medical Practice Act.

Graduates of such European medical colleges after January 1, 1943 may be considered for admission to Illinois examinations provided they present diplomas of graduation from approved medical colleges in the United States after attendance in such colleges for at least one year; and in addition, have served rotating interships of one year in approved hospitals in the United States.

(h) An applicant who presented a diploma of graduation from an approved school will not be accepted, if he was accorded advanced standing in such school based upon his prior education in an unapproved school.

Rule V—Examinations

1. Examinations for licensure to practice medicine in all of its branches shall be conducted in the English language and shall be in the following theoretical and practical areas of medicine:

THEORETICAL

Chemistry, Physiology, Anatomy, Pharmacology, Pathology, Bacteriology, Medicine, Public Health & Preventive Medicine, Obstetrics & Gynecology, Surgery, Pediatrics, Psychiatry

CLINICAL

General Practice of Medicine

2. Examinations for licensure to practice the treatment of human ailments without the use of drugs or medicine and without operative surgery shall be conducted in the English language and shall be in the following theoretical and practical subjects:

THEORETICAL

Chemistry & Physiology, Anatomy & Histology, Pathology & Bacteriology, Diagnosis, Hygiene & Medical Jurisprudence, Eye, Ear, Nose, & Throat, Dermatology, Pediatrics & Neurology, System of Practice, Obstetrics (of graduates of approved osteopathic colleges)

PRACTICAL

System of Practice

3. To be successful, applicants must receive general averages of 75% with no grade below 60 in the written examination, and a general average of 75% in the clinical or practical test.

Applicants applying for registration under Sections 12 and 12a of the Medical Practice Act shall be required to make general averages of 75% in the three subjects required for license to practice medicine and surgery in Illinois.

4. In case of failure in the first and second examinations applicants will be allowed credit on the following examination for all grades of 75 or more; but in case of failure in the third examination they must retake all written subjects at each subsequent examination. It is not required that the clinical or practical part of the examination be repeated after a passing grade of 75% has been received in that part of the examination.

5. Applicants who take the regular written examination conducted by the Department for licenses as Physicians and Surgeons shall be excused from taking the clinical test.

6. An applicant for registration as Physician and Surgeon who has been unsuccessful in five examinations will be deemed to be eligible for further examination upon receipt of proof that he has completed one year of residency training in an approved hospital training program in the United States received subsequent to the applicant's fifth failure.

7. An applicant who has been unsuccessful in five examinations for registration as a drugless practitioner will be eligible for reexamination upon receipt of proof that he has completed a course of study of 960 hours in a school which is accredited under the Medical Practice Act. This course must be received subsequent to the applicant's fifth failure.

8. An applicant who furnished proof of a course of study of 240 hours in a school of chiropractic recognized by the Department in order to be eligible for further examination under Section 9a of the Medical Practice Act will be considered as a new applicant and his grades of 75 per cent or more will be carried over to the second and third examinations.

RULE VI—RECIPROCITY

1. Each applicant for registration through reciprocity, either for the practice of medicine in all of its branches or for the treatment of human ailments without the use of drugs or medicine and without operative surgery, filed on forms provided by the Department, will be considered on its individual merits, provided the state or territory of original licensure grants a like privilege to persons licensed in Illinois.

2. If the application is not endorsed by officers of a state or county society it must be endorsed by two (2) physicians duly licensed to practice in some state in the United States.

3. Applicants for licensure through reciprocity or upon the basis of having passed the National Board Examination prior to January 1, 1964, must pass the clinical test conducted by this Department. Applicants upon the basis of the National Board Examination who completed Part III after January 1, 1964, are required to report for an interview with the Medical Examining Committee. The clinical test shall be such in the judgment of the Committee as will determine the qualifications of the applicant to practice medicine in all of its branches, taking into consideration the quality of medical education and clinical training or practical experience which the applicant has had, special honors or awards, publications in recognized and reputable journals, authorship of textbooks in medicine, and any other circumstance or attribute that the Committee accepts as evidence of an outstanding and proven ability in any branch of the field of medicine.

4. Graduates of Chiropractic colleges whose applications for registration in Illinois by reciprocity are approved, shall be required to pass a written examination in theory in addition to a practical test before the chiropractic examiner.

RULE VII—LICENSURE

1. An examinate who successfully completes his medical examination must secure his certificate of licensure within one year from the date of his examination.

2. The Department will not issue a duplicate certificate of registration to practice medicine in all of its branches, or to treat human ailments without the use of drugs or medicine and without operative surgery, unless proof satisfactory to the Department and the Committee is presented that the original certificate was destroyed; or in case of change of name when the original certificate is returned for cancellation, together with satisfactory legal proof of such change of name.

3. A license to practice medicine in Illinois

shall be a requisite for a residency in an Illinois hospital.

Rule VIII—Temporary Certificates of Registration

1. Any person not licensed to practice medicine in all of its branches in the State of Illinois who wishes to pursue a program of graduate or specialty or residency training in this State, must be the holder of a Temporary Certificate of Registration issued by the Department under the provisions of Section 11a of the Medical Practice Act of Illinois and in accordance with the provisions of the within Rules.

2. Application for a Temporary Certificate must be made on blank forms prepared and furnished by the Department. It must be submitted to the Department together with evidence satisfactory to the Department that applicant meets the requirements of Section 11a of the Illinois Medical Practice Act and that if his application is approved he will be accepted or appointed for the residency training in the hospital designated in such application.

3. A Temporary Certificate of Registration will be issued on behalf of an otherwise qualified applicant only for residency or specialty training in a hospital situated in this State which is approved by the Department for the purpose of such training. An approved hospital is one which in the judgment of the Department is qualified to offer such training, and which shall comply with the within Rules.

4. Written notice of the Department's final action on every application for a Temporary Certificate of Registration shall be given to the applicant and the hospital designated therein; when such application is approved the Temporary Certificate of Registration shall be delivered or mailed to the hospital designated therein and shall be kept in the care and custody of such hospital. The applicant shall not commence such specialty or residency training before he or the hospital receives written notification of approval of his application.

5. A Temporary Certificate of Registration shall not be valid for longer than one year after issuance thereof and may be renewed from time to time, in the discretion of the Department, for a period of not more than one year each time. Application for renewal must be made on forms prepared and furnished by the Department and the Temporary Certificate of Registration sought to be renewed must be submitted therewith to the Department.

6. When any person in whose behalf a Temporary Certificate of Registration has been issued shall be discharged or shall terminate his specialty or residency training in the hospital designated therein, such hospital shall immediately deliver or mail by registered mail to the Department his Temporary Certificate of Registration and written notice of the reason for return of same.

7. A Temporary Certificate of Registration is not transferable without prior notice to and approval by the Department. If the holder of a Temporary Certificate of Registration wishes to change to another training program in the approved hospital designated therein, or he wishes to enter a training program in another approved hospital, he must make application on Forms furnished by the Department. His current Temporary Certificate of Registration must accompany such application and he cannot thereafter continue in the training program designated on such current Certificate, and he may not commence such other training program until a Temporary Certificate of Registration has been issued therefor.

8. Not more than one Temporary Certificate of Registration shall be issued to any person for the same period of time. A person on whose behalf a Temporary Certificate of Registration has been issued is limited in the practice of medicine to the performing of such acts as may be prescribed by and incidental to his program of residency training in the hospital designated in his Temporary Certificate of Registration, and he cannot otherwise engage in the practice of medicine in the State of Illinois.

9. Whenever, under the within Rules, a hospital is required to deliver or return a Temporary Certificate of Registration to the Department, in case, because of the loss or destruction of such Certificate, or for any other reason, such hospital shall be unable immediately so to deliver or mail such Certificate, such hospital shall immediately mail or deliver to the Department a written explanation in detail of such inability.

10. The holder of a Temporary Certificate of Registration is not barred thereby from becoming eligible for admission to the Department examination for a license to practice medicine in Illinois if he otherwise meets the requirements for admission to such examination and if such person should fail to pass such examination such failure shall not bar him from completing his training program.

Rule IX—Limited Licenses to Practice in State Hospitals

1. Each application made on forms provided by the Department will be considered on its own merits.

2. The State Hospital at which the applicant will practice under the supervision of a medical officer, shall signify to the Department that the hospital will appoint the applicant in the event he receives a Limited License.

3. Any applicant for a Limited License who has failed in more than three examinations for licensure under the Illinois Medical Practice Act shall not be eligible for a Limited License.

ECFMG REQUIREMENTS

The Education Council for Foreign Medical Graduates (ECFMG) commenced operations in

October, 1957. Sponsors of this agency are the American Hospital Association, American Medical Association, Association of American Medical Colleges, and Federation of State Medical Boards of the United States. ECFMG gives two examinations a year to foreign medical graduates. The examinations test the graduate's general knowledge of medicine and command of English.

Persons successfully passing this examination are granted an ECFMG certificate. This certificate in the State of Illinois is **not a substitute** for nor is it the equivalent of licensure to practice medicine. It simply indicates that the holder's command of English has been tested and found adequate for assuming an internship in an American hospital. The holder of such a certificate may not practice medicine in any degree in a hospital in Illinois unless he is within one of the categories outlined above.

Offenses Listed

An unlicensed person who commits any of the following acts regardless of whether the same be committed within or without a hospital is guilty of practicing medicine without a license—a criminal offense:

1. Hold himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings.
2. Suggest, recommend or prescribe any form of treatment for the palliation, relief or cure of any physical or mental ailment of a person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever.
3. Diagnosticate or attempt to diagnosticate any ailment or supposed ailment of another.
4. Operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment of another.
5. Maintain an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment.
6. Attach the title Doctor, Physician, Surgeon, M.D., or any other word or abbreviation to his name, indicative that he is engaged in the treatment of human ailments as a business.

(*Medical Practice Act.* [Chp. 91, Sec. 16i, Paragraph 24, *1967 Rev. Stat.*])

Manifestly, the enforcement of the Medical Practice Act with respect to the elimination of unlicensed persons practicing medicine in a hospital is dependent upon co-operation by responsible persons within the hospital. It should be noted that lack of co-operation or failure to meet responsibilities can in a proper case be translated into criminal liability and disciplinary action resulting in revocation or suspenson of a license to practice medicine as follows:

1. The unlicensed person practicing medicine is committing a criminal offense.
2. A hospital administrator who assigns an unlicensed person to duties which involve his practicing medicine may subject himself to the criminal offense of aiding and abetting such unlicensed person to illegally practice medicine, and the same may be true of a hospital chief of staff or department head if in the nature of his duties he is directly responsible for assigning such duties to the unlicensed person.
3. A licensed doctor may have his license suspended or revoked if he has professional connection or association with another who is illegally practicing medicine. A chief of staff who knowingly allows such person to illegally practice medicine, or in a proper case, any member of the medical staff of a hospital may subject himself to disciplinary action against his license.
4. A licensed doctor may have his license suspended or revoked for unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

 A member of the medical staff of a hospital may place himself within such conduct if he neglects, fails or refuses to fulfill his responsibilities while on emergency room call.

Other Examining Boards

Other examining boards operating under the jurisdiction of the Department of Registration and Education are:

Chiropody-Podiatry Examining Committee
Charles H. Delano, D.P.M.
Alva J. Harler, D.S.C.
Theodore S. Hollingsworth, D.P.M.

Dental Examining Committee
Dr. Hugh D. Burke
Dr. Ralph H. Council
Dr. Herbert Gustavson
Dr. Sidney Neuwirth
Dr. William T. Osmanski
Dr. Richard Schmitz
Dr. Adrian L. Swanson

Committee of Nurse Examiners
Miss Patricia A. Wagner, Prof.
Mrs. Donna Hessler
Sr. Mary Frances Cooke
Mrs. Ina Ingwersen
Miss Lillian G. Oertel
Mrs. Harriet S. Olson
Miss Marion Lennan

Optometry Examining Committee
Jose E. Aponte, O.D.
Irving C. Morgan, O.D.
Gene Ossello, O.D.
Robert W. Stoelzle, O.D.
Floyd Woods, O.D.

Illinois State Board of Pharmacy
Mr. John Barlow
Mr. Louis Gdalman
Mr. Richard Hilden
Mr. Fred L. Janes
Dr. Daniel Nona
Mr. Harry T. Ose
Mr. Philip Sacks

Physical Therapy Examining Committee
Mr. Robert Babbs
Miss Vilma Evans
Mr. James Mason Gray
Mr. John J. Mustari
Dr. Arthur A. Rodriquez

Psychologists Examining Committee
Mr. Roderick W. Pugh
Dr. Helen Sunukjian
Dr. Philip Ash
Dr. Roy Brener
Dr. Wendell Dysinger

DIVISION OF VOCATIONAL REHABILITATION

The Board of Vocational Education and Rehabilitation is a statutory body, established to administer, through two operating divisions, the state program of vocational and technical education pursuant to the Federal Vocational Education Act as amended, and the state program of vocational rehabilitation pursuant to the Federal Vocational Rehabilitation Act as amended.

Board of Vocational Education and Rehabilitation

Statutory Members

Dr. Michael J. Bakalis
Superintendent of Public Instruction
302 State Office Building, Springfield 62706

Gordon L. Ropp, Director
Department of Agriculture
Junior Livestock Bldg, State Fairgrounds,
Springfield 62706

William Robinson, Director
Department of Registration & Education
628 East Adams Street, Springfield 62706

Albert J. Glass, M.D., Director
Department of Mental Health
401 State Office Building, Springfield 62706

Barney J. Grabiec, Director
Department of Labor
103 State Office Building, Springfield 62706

Franklin D. Yoder, M.D., Director
Department of Public Health
535 West Jefferson, Springfield 62706

Edward T. Weaver, Director
Department of Children & Family Services
524 South Second-Lincoln Towers, Springfield 62706

Lay Members

James W. Cook, Chairman of the Board
1200 Whitebridge Hill, Winnetka 60093

Mr. Richard Ehrman, Manager Relations
General Electric Company
Route 66 and Towanda Avenue, Bloomington 61701

Mr. Robert Friedlander, Consultant
135 South LaSalle Street, Chicago 60603

Mr. Stanley Hutchison, President
Washington National Corporation, Evanston 60201

Mr. Stuart Mamer, Attorney
Thomas, Mulliken & Mamer
First National Bank Building, Champaign 61820

Mr. Warner Saunders, Executive Director
Better Boys Foundation
1512 South Pulaski Road, Chicago 60623

ILLINOIS REGIONAL MEDICAL PROGRAM
REGIONAL ADVISORY GROUP

The Illinois Regional Medical Program, which began in 1967, is a federally funded but autonomous organization charged with improving the health care of the citizens of the state of Illinois. The program objectives are a single standard of high quality health care, provided with maximum effectiveness at minimal cost, and accessible to all. IRMP supports and engages in activities aimed at: 1) improving the health care delivery system 2) increasing the availability and capability of health care personnel and 3) controlling major diseases. The Regional Advisory Group, the policy-making body of the IRMP, must approve all project applications for funding. The RAG is composed of representatives from the medical profession, allied health professions, hospital administration, planning agencies, voluntary and official health groups, medical schools and teaching hospitals in the state, as well as members of the general public familiar with the financing of, and the need for health care.

Regional Advisory Group

Dexter Nelson, M.D., Princeton, *Chairman*
John E. Boyd, Chicago, *Vice-Chairman*
Leonidas H. Berry, M.D., Chicago
Henry B. Betts, M.D., Chicago
Daniel K. Bloomfield, M.D., Champaign
Charles D. Branch, M.C., Peoria
Alexander Braze, M.D., Rockford
Andrew Brislin, M.D., Chicago
Murray Brown, M.D., Chicago
Donald J. Caseley, M.D., Chicago
Donald P. Colleton, Chicago
Louis deBoer, Chicago

David P. Earle, M.D., Chicago
Miss Vilma Evans, R.P.T., Danville
Miss Cecelia Fennessy, R.N., Chicago
Stanley Goldstein, M.D., Decatur
John Grede, Ph.D., Chicago
William J. Greek, D.D.S., Springfield
Arthur L. Grist, Edwardsville
William J. Grove, M.D., Chicago
Emanuel Hallowitz, Chicago
Ronald G. Hansen, Ph.D., Carbondale
Clifford Hathway, Peoria
George K. Hendrix, Springfield
Leon O. Jacobson, M.D., Chicago
Allen Kelly, Eldorado
Robert A. Kistner, D.O., M.D., Chicago
Mrs. Marian Lamet, Warsaw
Robert B. Lawson, M.D., Chicago
August P. Lemberger, Ph.D., Chicago
Mark H. Lepper, M.D., Chicago
LeRoy P. Levitt, M.D., Chicago
W. Henderson May, Springfield
E. Duke McNeil, Chicago
Richard H. Moy, M.D., Springfield
Robert J. Parker, M.D., Bloomington
James W. Phillips, Chicago
Caesar Portes, M.D., Chicago
Will Rasmussen, Chicago
Edward F. Scanlon, M.D., Evanston
Berry Seng, M.D., Morris
Maynard Shapiro, M.D., Chicago
Reverend Reuben A. Sheares, II, Chicago
Hiram Sibley, Chicago
Albert Snoke, M.D., Chicago
John C. Troxel, M.D., Chicago
Charles Turner, Chicago
Arthur Vasquez, Chicago
Gail L. Warden, Chicago
J. A. Wells, M.D., Maywood
Franklin D. Yoder, M.D., Springfield

Number in parenthesis indicates number of beds in hospital. Initial preceding number refers to the type of control, as follows:

A—Corporation
B—Non-profit association or corporation
C—Privately owned and operated
D—City
E—County
F—Hospital District
G—Sanitarium District
H—Township
I—State
J—Federal

HOSPITALS WITH SPECIAL TYPE OF SERVICE

		Type of Service
CHICAGO (Cook)	Booth Memorial Hospital (A-19)	Maternity
	Chicago Eye, Ear, Nose and Throat Hospital (B-37)	EENT
	Chicago State Tuberculosis Sanitarium (B-345)	TB
	The Children's Memorial Hospital (A-240)	Pediatric
	Fox River Hospital (B-108)	Chronic
	Halco Hospital, Inc. (C-10)	Alcoholic
	LaRabida Children's Hospital and Research Center (A-104)	Pediatric Chronic
	Martha Washington Hospital (B-42)	Alcoholic
	Municipal Contagious Disease Hospital (A-201)	Contagious Disease
	Municipal Tuberculosis Sanitarium (B-620)	TB
	Rehabilitation Institute of Chicago (B-71)	Rehabilitation
	St. Vincent's Infant Hospital (B-65)	Pediatric
	Schwab Rehabilitation Hospital (B-88)	Rehabilitation
	Shriners Hospital for Crippled Children (A-68)	Orthopedic, Pediatric
FAIRVIEW HEIGHTS (St. Clair)	Pleasant View Sanatorium (B-25)	TB
HINSDALE (Cook)	The Suburban Cook County Tuberculosis Sanitarium District (B-153)	TB

MACKINAW (Tazewell)	Oak Knoll Sanitorium (E-32)	TB
MOOSEHEART (Kane)	Moosehart Hospital (B-43)	Pediatric
MOUNT VERNON (Jefferson)	Mount Vernon State Tuberculosis Sanitarium (B-73)	TB
OAK FOREST (Cook)	Oak Forest Hospital (E-2,211)	Chronic
OTTAWA (LaSalle)	Ottawa General Hospital (B-51)	Chronic
PEORIA (Peoria)	Peoria Municipal Tuberculosis Sanitarium (D-57)	TB
ROCKFORD (Winnebago)	Rockford Municipal Tuberculosis Sanitarium (D-45)	TB
ROCK ISLAND (Rock Island)	Rock Island County Tuberculosis Sanitorium (E-54)	TB
SPRINGFIELD (Sangamon)	St. John's Sanitorium (B-65)	TB
URBANA (Champaign)	Outlook Champaign County Tuberculosis Sanitorium (E-25)	TB
WAUKEGAN (Lake)	Lake County Tuberculosis Sanatorium (E-90)	TB
WEDRON (LaSalle)	St. Joseph's Health Resort and Sanitarium (B-97)	Medical-Chronic

PRIVATE MENTAL HOSPITALS

AURORA (Kane)
- Mercyville Institute of Mental Health (B-110)

CHICAGO (Cook)
- Fairview Hospital (C-135)
- Nicholas J. Pritzker Center (B-40)
- Ridgeway Hospital (B-99)

DES PLAINES (Cook)
- Forest Hospital (C-137)

ELGIN (Kane)
- Resthaven Hospital (C-100)

FOREST PARK (Cook)
- Riveredge (C-147)

STATE MENTAL HOSPITALS

ANNA (Union)
- Anna State Hospital

CENTRALIA (Madison)
- Warren G. Murray Children's Center

CHICAGO (Cook)
- Chicago-Read Mental Health Center

EAST MOLINE (Rock Island)
- East Moline State Hospital

ELGIN (Kane)
- Elgin State Hospital

GALESBURG (Knox)
- Galesburg State Research Hospital

JACKSONVILLE (Morgan)
- Jacksonville State Hospital

KANKAKEE (Kankakee)
- Kankakee State Hospital

MANTENO (Kankakee)
- Manteno State Hospital

CHESTER (Randolph)
- Illinois Security Hospital

PEORIA (Peoria)
- Peoria State Hospital

TINLEY PARK (Cook)
- Tinley Park Mental Health Center

STATE INSTITUTIONS FOR MENTALLY RETARDED

CHICAGO (Cook)
- Illinois State Pediatric Institute

DIXON (Lee)
- Dixon State School

DWIGHT (Livingston)
- William W. Fox Children's Center

HARRISBURG (Saline)
- A. L. Bowen Children's Center

LINCOLN (Logan)
- Lincoln State School

LICENSED CLINICAL LABORATORIES

ALTON
Stromsdorfer Medical Laboratory
604 E. Broadway, Rm. 101 62002

ARGO
*Argo Clinical Laboratory
6252 Archer Road 60501

ARLINGTON HEIGHTS
*Village Medical Laboratory
1009 S. Evergreen 60005
*Arlington Medical Laboratory
1430 N. Arlington Heights Road 60004

AURORA
*Clinical Laboratory
143 South Lincoln 60505

BARRINGTON
*Barrington Medical Laboratory
606 S. Northwest Hwy. 60010

BELLEVILLE
*St. Clair Medical Laboratory
301 W. Lincoln Street 62221

BENTON
Benton Medical Center Laboratory
205 Bailey Lane 62812

BERKELEY, CALIFORNIA
Solano Laboratories, Inc.
2113 Dwight Way 94704

BERWYN
Cermak Road Medical Laboratories
7120 W. Cermak Road 60402
*Kenilworth Laboratory
6905-A West Cermak Road 60402
Public Health District, Town of Berwyn
6600-26th Street 60402
Stickney Township Public Health Laboratory
6721 West 40th Street 60402

BLOOMINGTON
*Bloomington Cornbelt Bio-Chemical, Inc.
705 North East 61701
Clinical and Surgical Pathology Laboratory
211 E. Jefferson St. 61701
Medical Arts Building Laboratory
2304 E. Oakland Ave. 61701

BROADVIEW
*Broadview Physicians Laboratory
2200 W. Roosevelt Rd. 60153

BUFFALO GROVE
Buffalo Grove Medical Center Lab.
88 E. Dundee Ave. 60090

CANTON
Coleman Clinic Laboratory
175 South Main 61520

CENTRALIA
Centralia X-ray Laboratories
418 South Poplar 62801

CHAMPAIGN
*Doctors Building Laboratory
301 E. Springfield 61820
Medical Arts Laboratory
302 E. Stoughton 61820

CHICAGO
*A & D Medical Laboratory, Inc.
3848 West 63rd Street 60629
A-C Medical Laboratory
3512 West 26th Street 60623
Abel Laboratory, Inc.—Bio-Tech.
25 E. Washington St. 60602
*Almar Clinical Laboratory
2457 W. Peterson Ave. 60645
American Clinical Testing Laboratory
30 W. Washington St. 60602
*Antillas Medical Laboratory
3109 W. Armitage Ave. 60647
*Arcade Clinical Laboratory
6904 N. Sheridan Rd. 60626
Archer Clinical Laboratory
4176 Archer 60632
*Ashland Clinical Laboratory
1710 S. Ashland 60608
*Associated Medical Laboratory, Inc.
4753 N. Broadway 60604
*Auburn Clinical Laboratory
946 West 79th Street 60620
Augusta Clinical Laboratory
3454 N. Lincoln Ave. 60657
*Avenue Medical Laboratory
11318 S. Michigan Ave. 60628
*Bel-Aire Medical Building Laboratory
8501 S. Cottage Grove Ave. 60619
Beverly Clinical Laboratory
9451 South Hoyne 60620
*Beverly Sheridan Laboratory, Inc.
9449½ S. Ashland Ave. 60620
*Brooks Clinical Laboratory
4006 Milwaukee Avenue 60641
*Aaron S. Cahan, M.D. Laboratory
4010 W. Madison Street 60624
Campos Laboratory
1608 N. Milwaukee 60647
Central Medical Building Laboratory
3929 N. Central Ave. 60634
*Chatham Avalon Clinical Laboratory
8222 S. Martin Luther King, Jr. Drive 60619
Chicago Board of Health—Division of Laboratories
Lower Level—Chicago Civic Center 60602
Chicago Park District Medical Laboratory
425 East 14th Blvd. 60605
Chicago Health Center Laboratory
15 S. Wacker Drive 60619
Chicago Physicians Medical Laboratory, Inc.
4555 N. Broadway 60640
*Clearing Industrial Clinic, Inc.
5548 W. 65th Street 60638
*Colonial Medical Arts Laboratory
2024 West 79th Street 60620
*Community Medical Laboratory
3613 W. Roosevelt Rd. 60624
Continental Insurance Company
360 W. Jackson Blvd. 60606

Crawford Medical Arts Laboratory
6449 S. Pulaski Road 60629
Cytodiagnostic Laboratory, Inc.
25 E. Washington 60602
Division Medical Laboratory, Inc.
2625 W. Division St. 60622
Division Clinical Laboratory
5025 W. Division St. 60651
Doctors Building Laboratory
2800 West 87th 60652
*Doctors Medical Laboratory, Inc.
11440 S. Michigan Ave. 60628
Duke Laboratories
4846 W. Chicago Ave. 60651
Field Clinic Laboratory
4600 N. Ravenswood Ave. 60640
Fordon Medical Laboratory
2656 W. 63rd Street 60629
*Foster Western Laboratories, Inc.
5214 N. Western Ave. 60625
Francis Laboratory
122 S. Michigan Ave. 60603
*Garfield Medical Laboratories
818 W. Garfield Blvd. 60609
*Gerber X-Ray and Clinical Laboratory
2400 West Devon 60645
*Gerson Clinical Laboratory
1 North Pulaski 60625
Grant Hospital Laboratory
551 W. Grant Place 60614
*Highland Medical Laboratory
7922 S. Ashland Ave. 60620
Highland View Medical Center
8556 S. Ashland Ave. 60620
*Humboldt Clinical Laboratory
2018 S. Ashland Ave. 60608
*Hyde Park Medical Laboratory
5240 South Harper 60615
Irving Park Clinical Laboratory
3959 N. Lincoln Ave. 60613
*Jeffrey Center Clinical Laboratory
200 E. 75th St. 60619
*K & K Clinical Laboratory
5935 W. Addison 60634
*Kendon Medical Laboratory, Inc.
8625 S. Cicero Avenue 60658
*Laboratory Associates Inc.
1910 N. Sedwick 60614
Laboratory of Union Health Service
1634 West Polk 60612
*Letho Clinical Laboratories
1325 S. Racine Avenue 60608
Logan Square X-Ray and Clinical Laboratory, Inc.
2815 N. Kimball 60618
*Marquette Medical Laboratory
6132 South Kedzie 60629
*Mart X-Ray Laboratory Company
7-110 Merchandise Mart 60654
Mason-Barron Laboratories Inc.
Sub. of Damon Corporation
9204 Commercial Ave. 60617
Mason-Barron Laboratories, Inc.
Sub. of Damon Corporation
1525 E. 53rd St. 60615
*Mason-Barron Laboratories, Inc.
Sub. of Damon Corporation
55 E. Washington St. 60602
*Mason-Barron Laboratories, Inc.
Sub. of Damon Corporation
1737 W. Howard St. 60626
*Mason-Barron Pathology Clinical Laboratory
2056 North Clark Street 60614
*Medic Clinical Laboratory
6317 S. Western Avenue 60636
*Medical Association of Chicago Clinic Laboratory
3233 South King Drive 60616
*Medical Center Clinical Laboratory
3528 N. Ashland Ave. 60657
Medical Service Center
2320 W. Petersen Ave. 60045
Mediscreen Laboratory
5 South Wabash 60603
Meyer Medical Group
10444 S. Kedzie Avenue 60655
Meyer Medical Group
653 West 79th Street 60620
*Midwest Cytology Laboratory
5707 North Ashland 60626
*Molay Medical Laboratory
185 North Wabash 60601
*North Kimball Medical Laboratory
1579 N. Milwaukee Ave. 60622
Northwest Medical Laboratory
2006 West Chicago 60622
*Norven Medical Laboratories Inc.
1816 W. Irving Park Road 60613
Norwest Medical Laboratory
2336 West Chicago 60622
*Ogden Hill Medical Laboratory
3451 West 63rd Street 60629
*Omens Medical Building X-Ray and Clinical Laboratory
5720 West North Avenue 60639
*P-M Clinical Laboratories
155 E. Ohio St. 60611
*P. M. D. Clinical Laboratory
2017 West 95th Street 60643
*Park-Grove Medical Laboratory
8048 S. Cottage Grove 60619
Parke DeWatt Laboratories, Inc.
111 North Wabash Ave. 60602
Parkside Clinical Laboratory
7915 S. King Drive 60619
*Parkway Laboratory
408 E. Marquette Road 60637
*Peterson Western Clinical Laboratory
2424 West Peterson 60645
*Physicians and Surgeons Laboratory
6710 West North Ave. 60635
Plaza View X-Ray and Lab., Inc.
2715 North Central Ave. 60639
Post Graduate Hospital Laboratory
2400 S. Dearborn Street 60616
Preventi-Med Miltitest Center
155 E. Ohio St. 60611
Robard Corporation
30 North Michigan 60602
*S & S Medical Laboratory, Inc.
532 East 47th Street 60653
*Sarian Medical Laboratory
6257 South Archer Ave. 60638
*Sauganash X-Ray and Medical Laboratory, Inc.
4833 W. Peterson 60646
*South Central Medical Laboratory
5050 South State 60609

Southwestern Laboratory, Inc.
7939 S. Western Avenue 60620
Tenco Hydro-Aerosciences Inc.
4921 S. Archer Ave. 60632
Thompson X-Ray and Clinical Laboratory
1150 North State Street 60610
*Thornburg Clinical Laboratory
841 East 63rd Street 60637
*Thornburg Clinical Laboratory
720 N. Michigan Ave. 60611
Richard W. Tiecke, D.D.S.
211 E. Chicago Avenue 60611
United Air Lines Medical Department
P.O. Box 66100 60666
*United Medical Laboratories, Inc.
8 S. Michigan Ave., Room 1412 60603
*University Laboratory
5 South Wabash Avenue 60603
*Victoria Laboratories, Ltd.
5872 N. Milwaukee Ave., Suite B 60646
*West Lawn Medical Laboratory
4255 West 63rd Street 60629
*Westerly Medical Laboratory
10404 South Western 60643
*Westridge Clinical Laboratory
6450 N. California 60645
*Westside Clinical Laboratory
3808 W. Roosevelt Rd. 60624
*Zeitlin X-Ray and Clinical Laboratory
2800 Milwaukee Avenue 60618
*63rd Medical Laboratory
749 West 63rd Street 60621
*95th Street X-Ray and Clinical Laboratory
243 West 95th Street 60628
United Airlines Medical Department Laboratory
O'Hare Field Station, Box 66140 60666

CLAYTON, MISSOURI
Cooper Medical Laboratory
141 North Meramec 63105

COLLINSVILLE
Appleton Laboratory
416 E. Main Street 62201

DEKALB
DeGraffenried and Fisher
720 Haish Boulevard 60115
*DeGraffenried Fisher Laboratory
1838 Sycamore Road 60115
DeKalb Medical Center Laboratory
901 North First Street 60115

DECATUR
*Central Clinical Laboratory
1314 North Main 62526
Macon County Health Department Laboratory
1085 South Main Street 62521

DES PLAINES
*Dempster-Lyman Clinical Laboratory and X-Ray
2404 Dempster 60016
*Deridge Clinical Laboratory
3200 Dempster Street 60016
Fahey Medical Center
581 Golf Road 60016

DES PLAINES
Medical Service Center
8700 West Dempster, Des Plaines 60016

DETROIT, MICHIGAN
Central Laboratories, Inc.
312 David Whitney Bldg. 48226

DOWNERS GROVE
Downers Grove Medical Laboratory
4333 Main Street 60515

EAST ST. LOUIS
*Appleton Laboratory
234 Collinsville Ave. 62201
*Clinical Laboratory
4601 State Street 62201

ELGIN
*Fox Valley Medical Laboratory
860 E. Summit Street 60120

ELK GROVE VILLAGE
Medical Laboratory and X-Ray, Inc.
762 Arlington Hts. Rd. 60007

ELMHURST
*Haven Clinical Laboratory
103 Haven Road 60126
Elmhurst Pathology Associates, S.C.
135 South Kenilworth 60126
*Mason-Barron Laboratories Inc.
Sub. of Damon Corporation
533 W. North Ave. 60126
Medical Service Center
188 Industrial Drive, Room 120 60126
*Sandahl Medical Laboratory
135 S. Kenilworth 60126

ELMONT, N.Y.
Bio-Chemex Laboratories, Inc.
1271 Hempstead Turnpike 11003

ELMWOOD PARK
*Austin Clinical Laboratory
7830 W. North Ave. 60635

EVANSTON
*Cos Building Laboratory
2500 Ridge Avenue 60201
Crain Reference Laboratory
1532 Crain Street 60202
*Gyne-Cytology Laboratory, Inc.
636 Church Street 60201
Evanston-North Shore Health Dept.
Box 870 60201
1101 Clinical Laboratory
1101 Howard Street 60202
*Mason-Barron Laboratories, Inc.
Sub. of Damon Corporation
636 Church Street 60201

EVANSVILLE, INDIANA
Mid-America Pathology Serv. Inc.
3700 Bellemeade Avenue 47701

EVERGREEN PARK
*Anatomic and Clinical Pathology
P.O. Box 42919 60642
Evergreen Park Medical Laboratory
9760 South Kedzie Ave. 60642
*Francisco Medical Laboratory
9450 S. Francisco Ave. 60642
Medical Service Center
9730 S. Western Ave., 60643

Mosquera Clinical Laboratory
3830 West 95th Street 60642
*North Beverly Clinical Laboratory
3759 West 95th Street 60642

FOREST PARK
*Bowers Laboratory
7318 Madison Street 60130

FRANKLIN PARK
*Franklin Park Medical Laboratory, Inc.
9711 Grand 60131

FREEPORT

Freeport Clinic Laboratory
222 W. Exchange Street 61032
Freeport Medical Clinic
324 West Galena 61032
Northwest Illinois Laboratory
319 North West Avenue 61032

GALESBURG
*Galesburg Clinic Laboratory
320 N. Kellogg Street 61401

GLEN ELLYN
Glen Ellyn Clinic Laboratory
454 Pennsylvania Avenue 60137
Glen Ellyn Medical Laboratory
526 Crescent Boulevard 60137

GLENVIEW
*Northwest Suburban X-Ray and Clinical Laboratory
924 Waukegan Road 60025

GRANVILLE
*Physicians Clinical Laboratory 61326

HAMMOND, INDIANA
Physicians Laboratory
5246 Hohman Ave. 46320

HARVEY
Community Medical Center
15900 Carol Avenue 60426
*Graham Clinical Laboratory
468 East 147th Street 60426
Weiss Clinical Laboratory
15318 Center Avenue 60426

HIGHLAND PARK
*Mason-Barron Laboratories Inc.
Sub. of Damon Corporation
1950 Sheridan Road 60035

HINSDALE
*Colton Microbiology Laboratory
550 N. Monroe St. 60521
*Mason-Barron Laboratories Inc.
Sub. of Damon Corporation
40 S. Clay 60521

JACKSONVILLE
Medical Development Corporation
1440 West Walnut 62650

JERSEYVILLE
Miller Medical Laboratory
123A West Pearl Street 62052

JOLIET
*Associate Pathologists
2112 West Jefferson 60435
*Central Laboratory
57 W. Jefferson Street 60431
*Osler Laboratories, Inc.
120 North Scott Street 60431
*Prescription Shop Laboratory
55 N. Ottawa Street 60431

KANKAKEE
*Medical Center Laboratory
1309 East Court Street 60901

LAGRANGE
*LaGrange Medical Building Laboratory
47 South Sixth 60525

LAGRANGE PARK
Village Market Medical Laboratory
360 Sherwood Court 60525

LASALLE
Hygienic Institute Laboratory
151 Fifth Street 61301
*Medical Laboratory
555-2nd Street 61301

LANSING
*DeGraff Clinical Laboratory
3341 Ridge Road 60438
*Labreco Inc.
3341 Ridge Road
Medical Service Center
18225 Burnham Avenue 60438

LEROY
V. K. Pliura, M.D. Laboratory
101 West School 61752

MACOMB
Winter and Rettenmaier
Professional Corporation
McDonough Dist. Hospital
525 E. Grant Street 61455

MARSEILLES
Carr Medical Laboratory
Main Street 61341

MAYWOOD
*Joslyn Clinic Laboratory
1908 St. Charles Road 60153

MCHENRY
*McHenry Medical Group
1110 N. Green Street 60050

MELROSE PARK
*Delm Medical Laboratory
1900 West Iowa 60160

MENDOTA
Mendota Community Hospital Laboratory
Memorial Drive 61342

MINONK
Illinois Valley Doctors Laboratory
118 W. 6th St. 61760

MOLINE
*Martin Clinical Laboratory
1520-7th Street 61265

Moline Public Hospital Laboratory
635-10th Avenue 61265
Quad-City Pathology Group
Lutheran Hospital 501-10th Avenue 61265

MORTON GROVE
*Sommerfeld Medical Laboratory, Inc.
5818 Dempster Street 60053

MOUNT PROSPECT
*Mount Prospect Clinical Laboratory
321 West Prospect Ave. 60056
*Prospect Clinical Laboratory
1060 W. Northwest Hwy. 60056
Professional Arts Medical Laboratory
221 West Prospect 60056

MUNDELEIN
Menolasino Laboratory, Inc.
1352 Armour Boulevard 60060

NORMAL
*Stroink Pathology Laboratories
900 Franklin Avenue 61761

NORTHBROOK
*A & M Clinical Laboratory
1500 Shermer Road 60062
Industrial Bio-Test Laboratories, Inc.
1810 N. Frontage Road 60062
*Northbrook Clinical and X-Ray Laboratory
1775 Walters 60062

OAK LAWN
Stickney Township Public Health Laboratory
5635 State Road 60459

OAK PARK
*American Medical Laboratory
6441 W. North Avenue 60302
*Arms Medical Laboratory
414 S. Oak Park Avenue 60302
*James B. Hartney, M.D.
410 Lake Street 60302
*McGregor Laboratory
6144 W. Roosevelt Road 60304
*Hill Clinical Laboratory, Inc.
1011 Lake Street 60301

OAKBROOK
Mason-Barron Laboratories, Inc.
Sub. of Damon Corporation
120 Oak Brook Center Mall 60521

OAK LAWN
*American Medical Laboratories
4817 W. 83rd St. 60459

OLYMPIA FIELDS
Athenia Park Medical and X-Ray Laboratory
2601 W. Lincoln Hwy. 60461

PALOS HEIGHTS
*Palos Medical Laboratory
12150 S. Harlem Avenue 60463

PARK FOREST
*South Suburban Medical Laboratory
2448 Western Avenue 60466

PEKIN
*Medical Laboratory, The
519 Margaret 61554

PEORIA
*M. B. Clinical Laboratory Corp.
818 West Main 61606
*Medical Center Laboratories
416 St. Marks Court 61603
Peoria Department of Health
2116 N. Sheridan Road 61604
*W. H. Schwarzendruber Laboratory
300 E. War Memorial Dr. 61614

ROCKFORD
Associated Pathologists
Swedish American Hospital 61101
*Associated Pathologist
1415 E. State Street 61108
*Medical Laboratory of Pathology
1221 E. State Street 61108
Rockford Health Department Laboratory
425 E. State Street 61104

ROLLING MEADOWS
Rolling Meadows Professional Laboratory
3407 Kirchoff Road 60008

ROSELLE
Sylvester Clinical Laboratory
225 E. Irving Park Road 60172

SANDWICH
Sandwich Comm. Hospital Laboratory
11 East Pleasant 60548

SKOKIE
Harry H. Hetz, M.D. Pathology Laboratories
4240 Dempster Street 60076
*North Suburban Clinical Laboratory
4801 Church Street 60076
*Mason-Barron Laboratories Inc.
Sub. of Damon Corporation
64 Old Orchard 60076

SOUTH HOLLAND
*Avenue Medical Laboratory
16234 South Louis Ave 60473

SPRINGFIELD
*Capitol Clinical Laboratories
1104 South 2nd Street 62704
*Physicians Medical Laboratory
501 N. 6th-Box 2178 62703
*Springfield Clinic
1025 South 7th Street 62703

STREATOR
Streator Medical Clinic
Westgate Plaza 61364
Streator Medical Clinic. S. C.
615 S. Bloomington St. 61364

ST. LOUIS, MO.
Allen Medical Laboratories
2821 N. Ballas Road 63131
Clinical Labs. of St. Louis, Inc.
100 N. Euclid 63108
Clinical Labs. of St. Louis, Inc.
3720 Washington Blvd. 63108
Midwest Medical Laboratory, Inc.
4141 Forest Park Blvd. 63108
Pathology Services, Inc.
52 Maryland Plaza 63108

SYCAMORE
Sycamore Municipal Hospital
225 Edward St. 60178

TINLEY PARK
*Affiliated Medical Laboratories
6785 W. 174th Street 60477

URBANA
Carle Clinic Laboratory
602 W. University 61801

UTICA
C. W. Atherton M.D. Laboratory
Rural Route #1 61373

VILLA PARK
*Ardmore Pharmacy, Inc.
317 S. Ardmore 60181
Villa Medical Arts Laboratory
10 E. Central Blvd. 60181

WAUKEGAN
*Besley-Waukegan Clinic
215 N. Sheridan Road 60085

*Physicians and Surgeons Laboratory
1616 Grand Avenue 60085
Standard Bio-Medical Laboratories, Inc.
521 Greenwood Avenue 60085

WHEATON
*Mason-Barron Pathology Laboratory
200 E. Willow 60187

WILMETTE
*Wilmette Clinical Laboratory
165 Green Bay Road 60091

WILMINGTON
Clinical Laboratory and X-Ray
107 S. Water Street 60481

WINNETKA
*Clinical-Technical Laboratory, Inc.
1048 Gage Street 60093
*Winnetka Clinical Laboratory
725 Elm Street 60093

ZION
*Zion Clinic Laboratory
2629 Sheridan Road 60099
*Medicare Certified

APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS
Illinois Department of Public Health
Division of Chronic Illness

Michael Reese Hospital and Medical Center
29th Street & Ellis Avenue
Chicago 60616
Alan Kanter, M.D.

Presbyterian-St. Luke's Hospital
1753 West Congress Parkway
Chicago 60612
Todd S. Ing, M.D.

Washington University School of Medicine
(Barnes Hospital)
660 South Euclid Avenue
St. Louis, Missouri 63110
Eduardo Slatopolsky, M.D.

Memorial Hospital
First and Miller Streets
Springfield 62701
Alton Morris, M.D.

Evanston Hospital
2650 Ridge Avenue
Evanston 60201
Bernard Adelson, M.D.

University Hospitals
Department of Medicine
1300 University Avenue
Madison, Wisconsin 53706
Arvin B. Weinstein, M.D.

University of Illinois Research and Educational Hospitals
840 South Wood Street
Chicago, 60612
Franklin Schwartz, M.D.

Mayo Clinic
Internal Medicine & Nephrology
Rochester, Minnesota 55901
William J. Johnson, M.D.

University of Chicago Hospitals & Clinics
(Includes LaRabida Sanitarium)
950 East 59th Street
Chicago 60637
Frank P. Stuart, M.D. — Adrian I. Katz, M.D.

Mount Sinai Hospital Medical Center
Fifteenth and California Avenues
Chicago 60608
Earl C. Smith, M.D.

Passavant Memorial Hospital
303 East Superior Street
Chicago 60611
Francesco del Greco, M.D.

West Suburban Hospital
518 North Austin Boulevard
Oak Park 60302
Robert C. Muehrcke, M.D.

Rockford Memorial Hospital
2300 North Rockton Avenue
Rockford 61101
Ewald T. Sorensen, M.D.

APPROVED RENAL DIALYSIS UNITS AND DIRECTORS
Illinois Department of Public Health
Division of Chronic Illness

The Children's Memorial Hospital
2300 Children's Plaza
Chicago 60614
Peter R. Lewy, M.D.

Cook County Hospital
1825 West Harrison Street
Chicago 60612
George Dunea, M.D.

Lake View Memorial Hospital
812 North Logan Avenue
Danville 61832
Joseph G. Ellis, M.D.

Mercy Hospital
1400 West Park Avenue
Urbana 61801
R. E. Tirona, M.D.

St. Joseph Hospital
2900 North Lake Shore Drive
Chicago 60657
Gordon Lang, M.D.

Galesburg Cottage Hospital
674 North Seminary Street
Galesburg 61401
Agha Babanoury, M.D.

Roosevelt Memorial Hospital
426 West Wisconsin Street
Chicago 60614
Franklin D. Schwartz, M.D.

Ingalls Memorial Hospital
15510 Page Avenue
Harvey 60426
Alexander B. White, M.D.

St. Francis Hospital
523 N. E. Glen Oak
Peoria 61603
Robert Pflederer, M.D.

For further information contact:
Mrs. Ruth S. Shriner, ACSW
Illinois Department of Public Health
535 West Jefferson Street
Springfield, Illinois 62706
Phone: (217) 525-6564

Dialysis for Veterans with kidney disease is available at:

Veterans Administration Hospital
Hines
A. R. Lavender, M.D.

Veterans Administration Research Hospital
Chicago
Peter Ivonovich, M.D.

ARTIFICIAL KIDNEYS FOR ACUTE POISONING CASES

For further information contact:
Richard H. Suhs, M.D., Chief Division of Disease Control
(Hazardous Substances & Poison Control Program)
Illinois Department of Public Health
535 West Jefferson, Springfield, Illinois 62706
Phone: (217) 525-7747

Copley Memorial Hospital
Lincoln & Weston Avenues
Aurora
Phone: 897-6021
Person in Charge:
Location in Hosp: Intensive Care

St. Elizabeth's Hospital
211 S. 3rd Street
Belleville
Phone: 234-2120
Person in Charge:
Location in Hosp: Intensive Care

Children's Memorial Hospital
2300 Children's Plaza
Chicago
Phone: 348-4040
Person in Charge: Dr. Peter Lewy
Location in Hosp: Nephrology

Cook County Hospital
1835 West Harrison
Chicago
Phone: 633-6000
Person in Charge: Dr. George Dunea
Location in Hosp: Ward 25 South

Edgewater Hospital
5700 N. Ashland Avenue
Chicago
Phone: 878-6000
Person in Charge: Dr. Rogelio Riera
Location in Hosp: Surgery

Michael Reese Hosp. & Medical Center
29th & Ellis Avenue
Chicago
Phone: 791-2000
Person in Charge: Dr. Allan Kanter
Location in Hosp: Renal Division Department of Medicine

ARTIFICIAL KIDNEY CENTERS

Mt. Sinai Hospital 15th & California Avenue Chicago	Phone: Person in Charge: Location in Hosp:	542-2000 Earl Smith, M.D. Medicine
Passavant Memorial Hospital 303 E. Chicago Chicago	Phone: Person in Charge: Location in Hosp:	944-4200 Francesco delGreco, M.D. Dialysis Center
Rush-Presbyterian-St. Lukes 1753 West Congress Parkway Chicago	Phone: Person in Charge: Location in Hosp:	942-5000 Dr. Todd Ing Division of Medicine
Roosevelt Memorial Hospital 426 W. Wisconsin Chicago	Phone: Person in Charge: Location in Hosp:	664-8000 Dr. Franklin Schwartz Hemodialysis
University of Chicago Hospital 950 E. 59th Chicago	Phone: Person in Charge: Location in Hosp:	947-5255 Dr. Adrian Katz Out Patient-Ambulatory Care
University of Illinois Hospital 840 S. Wood Street Chicago	Phone: Person in Charge: Location in Hosp:	663-6444 Dr. Franklin Schwartz Medical Nephrology
Lake View Memorial Hospital 812 N. Logan Avenue Danville	Phone: Person in Charge: Location in Hosp:	443-5000 J. G. Ellis, M.D. Adjacent to ICU
St. Joseph Hospital 277 Jefferson Avenue Elgin	Phone: Person in Charge: Location in Hosp:	741-5400 William T. Sheehy, M.D. Artificial Kidney Dept.
Memorial Hospital of DuPage Co 209 Avon Road Elmhurst	Phone: Person in Charge: Location in Hosp:	833-1400 Dr. J. J. Simonaitis Dept. of Medicine
Evanston Hospital 2650 Ridge Avenue Evanston	Phone: Person in Charge: Location in Hosp:	492-2000 Dr. Bernard Adelson Medicine-Section of Nephrology
Galesburg Cottage Hospital 674 N. Seminary St. Galesburg	Phone: Person in Charge: Location in Hosp:	343-4121 Agha Babanoury, M.D. Surgical Wing
Ingalls Memorial Hospital 15510 Page Avenue Harvey	Phone: Person in Charge: Location in Hosp:	333-2300 Mr. Alexander B. White ICU—North V
Loyola University Hospital 2160 South 1st Avenue Maywood	Phone: Person in Charge: Location in Hosp:	531-3800 Luis Cespedes, M.D. Renal Dialysis
West Suburban Hospital 518 N. Austin Blvd. Oak Park	Phone: Person in Charge: Location in Hosp:	383-6200 Dr. Robert Muehrcke Kidney Dialysis Center
St. Francis Hospital 530 N.E. Glen Oak Peoria	Phone: Person in Charge: Location in Hosp:	672-2000 Dr. R. A. Pflederer Hemodialysis
Rockford Memorial Hospital 2400 N. Rockton Rockford	Phone: Person in Charge: Location in Hosp:	968-6861 Dr. E. T. Sorensen Dept. of Medicine
Memorial Hospital 1st & Miller Springfield	Phone: Person in Charge: Location in Hosp:	528-2041 Dr. Alton J. Morris Dr. Richard Bilinsky
Mercy Hospital 1400 West Park Urbana	Phone: Person in Charge: Location in Hosp:	337-2157 Mrs. Jean Porterfield, R.N. Mr. Michael Luth Nursing Service

In addition to the hospitals in Illinois, we have also received information that the following hospital has an artificial kidney. This out of state hospital may be more accessible in some emergencies than those in Illinois:

Barnes Hospital
Barnes Hospital Plaza
St. Louis, Missouri

Phone: 367-6400
Person in Charge: Dr. Edwardo Slatapolsky
Location in Hosp: Renal Division

POISON CONTROL CENTERS IN ILLINOIS

For further information contact:
Richard H. Suhs, Chief, Division of Disease Control,
(Hazardous Substances and Poison Control Program)
Illinois Department of Public Health
535 W. Jefferson, Springfield 62706
Phone: (217) 525-7747

AURORA
Copley Memorial Hospital
Lincoln & Weston Avenues
896-3911
St. Joseph Mercy Hospital
1325 North Highland
859-2222

BELLEVILLE
Memorial Hospital
4501 North Park Dr.
233-7750, Ext. 250, 1, 2, 3

BELVIDERE
Highland Hospital
1625 S. State St.
547-5441

BERWYN
MacNeal Memorial Hospital
3249 S. Oak Park Ave.
484-2211 Ext. 311

BLOOMINGTON
Mennonite Hospital
807 North Main St.
828-5241, Ext. 312
St. Joseph Hospital
2200 E. Washington
662-3311, Ext. 352

CAIRO
St. Mary's Hospital
2020 Cedar St.
734-2400, Ext. 4233

CANTON
Graham Hospital Association
210 W. Walnut St.
647-5240, Ext. 230

CARBONDALE
Doctors Memorial Hospital
404 W. Main St.
457-4101, Ext. 341

CARTHAGE
Memorial Hospital
End South Adams St.
357-3131, Ext. 57

CENTRALIA
St. Mary's Hospital
400 N. Pleasant Ave.
532-6731

CHAMPAIGN
Burnham City Hospital
407 S. 4th
337-2533

CHANUTE AIR FORCE BASE*
United States Air Force Hospital
495-3134

CHESTER
Memorial Hospital
1900 State St.
826-4581

CHICAGO
Children's Memorial Hospital
2300 Children's Plaza
348-4040, Ext. 338
Cook County Hospital
1825 West Harrison Ave.
633-6542
University of Illinois Hospitals
840 South Wood St.
663-7297
Mercy Hospital
2510 Martin Luther King Dr.
842-4700, Ext. 281
Michael Reese Hospital
2929 S. Ellis
791-2050
Mt. Sinai Hospital
15th & California
542-2030
Municipal Contagious Disease San.
3026 South California Ave.
247-5000

Rush-Presbyterian-St. Lukes Medical Center
(Master Chicago Center for information, treatment & reference on poisoning)
1753 W. Congress Parkway
942-5969
Resurrection Hospital
7435 West Talcott Ave.
774-8000, Ext. 235
Wyler Children's Hospital
950 E. 59th St.
947-6231

DANVILLE
Lake View Memorial Hospital
812 N. Logan Ave.
443-5221
St. Elizabeth Hospital
600 Sager St.
442-6300

DECATUR
Decatur Memorial Hospital
2300 N. Edward St.
877-8121, Ext 676
St. Mary's Hospital
1800 E. Lake Shore Dr.
429-2966, Ext. 640

DES PLAINES
Holy Family Hospital
100 North River Road
297-1800, Ext. 856

*Limited for treatment of military personnel and families, except for indicated civilian emergencies.

EAST ST. LOUIS
Christian Welfare Hospital
1509 Illinois Ave.
874-7076, Ext. 232-216
St. Mary's Hospital
129 North 8th St.
274-1900, Ext. 204

EFFINGHAM
St. Anthony's Memorial Hospital
503 North Maple St.
342-2121, Ext. 211

ELGIN
St. Joseph's Hospital
277 Jefferson Ave.
741-5400, Ext. 65, 69
Sherman Hospital
934 Center St.
742-9800, Ext. 682

ELMHURST
Memorial Hospital of DuPage County
315 Schiller St.
833-1400, Ext. 550, 551

EVANSTON
Community Hospital
2040 Brown Ave.
869-5400, Ext. 54, 58
Evanston Hospital
2650 Ridge Ave.
492-6460
St. Francis Hospital
355 Ridge Ave.
492-2440

EVERGREEN PARK
Little Company of Mary Hospital
2800 W. 95th St.
HI5-6000

FAIRBURY
Fairbury Hospital
519 South Fifth St.
692-2346, Ext. 248

FREEPORT
Freeport Memorial Hospital
420 South Harlem Ave.
233-4131, Ext. 228

GALENA
The Galena Hospital District
Summit Street
777-1340

GALESBURG
Galesburg Cottage Hospital
674 North Seminary St.
343-4121, Ext. 356, 336
St. Mary's Hospital
239 South Cherry St.
343-3161, Ext. 210

GRANITE CITY
St. Elizabeth's Hospital
2100 Madison Ave.
876-2020, Ext. 224

HARVEY
Ingalls Memorial Hospital
15510 Page Ave.
333-2300, Ext. 787

HIGHLAND
St. Joseph Hospital
1515 Main St.
654-2171, Ext. 297-298

HIGHLAND PARK
Highland Park Hospital Foundation
718 Glenview Ave.
432-8000

HINSDALE
Hinsdale San. & Hospital
120 North Oak St.
323-2100, Ext. 336

HOOPESTON
Hoopeston Community Memorial Hospital
701 E. Orange
283-5531

JACKSONVILLE
Passavant Memorial Area Hospital
1600 West Walnut St.
245-9541

JOLIET
St. Joseph's Hospital
333 N. Madison St.
725-7133, Ext. 679, 680
Silver Cross Hospital
600 Walnut St.
729-7563

KANKAKEE
Riverside Hospital
350 N. Wall St.
933-1671, Ext. 606, 614
St. Mary's Hospital
150 South Fifth St.
939-4111, Ext. 735

KEWANEE
Kewanee Public Hospital
719 Elliott St.
853-3361, Ext. 219

LAKE FOREST
Lake Forest Hospital
660 North Westmoreland Road
234-5600, Ext. 608

LASALLE
St. Mary's Hospital
1015 O'Conor Ave.
223-0607

LIBERTYVILLE
Condell Memorial Hospital
Cleveland & Stewart Aves.
362-2900, Ext. 325, 326

LINCOLN
Abraham Lincoln Memorial Hospital
315 Eighth St.
732-2161, Ext. 346, 365

MACOMB
McDonough District Hospital
525 East Grant St.
833-4101, Ext. 433

MATTOON
Mem. Dist. Hosp. of Coles County
2101 Champaign Ave.
234-8881, Ext. 43, 29

MAYWOOD
Loyola University Hospital
2160 S. 1st Ave.
531-3000

McHENRY
McHenry Hospital
3516 West Waukegan Road
385-2200, Ext. 614

MELROSE PARK
Westlake Community Hospital
1225 Superior St.
681-3000, Ext. 226

MENDOTA
Mendota Community Hospital
Memorial Drive
539-7461, Ext. 221

MOLINE
Moline Public Hospital
635-10th Ave.
762-3651, Ext. 232

MONMOUTH
Community Memorial Hospital
1000 W. Harlem Ave.
734-3141, Ext. 224

MOUNT CARMEL
Wabash General Hospital
1418 College Drive
262-4121, Ext. 231

MOUNT VERNON
Good Samaritan Hospital
605 North Twelfth St.
242-4600

NAPERVILLE
Edward Hospital
South Washington St.
355-0450, Ext. 326

NORMAL
Brokaw Hospital
Virginia at Franklin Ave.
829-7685, Ext. 274

OAK LAWN
Christ Community Hospital
4440 West 95th St.
425-8000, Ext. 659, 660

OAK PARK
West Suburban Hospital
518 North Austin Blvd.
383-6200, Ext. 6747

OLNEY
Richland Memorial Hospital
800 East Locust St.
395-2131

OTTAWA
Ryburn Memorial Hospital
701 Clinton St.
433-3100, Ext. 48

PARK RIDGE
Lutheran General Hospital
1775 Dempster St.
692-2210, Ext. 1462, 1463

PEKIN
Pekin Memorial Hospital
14th & Court
347-1151, Ext. 241

PEORIA
Methodist Hospital
221 Northeast Glen Oak Ave.
685-6511, Ext. 250, 360
Proctor Community Hospital
5409 North Knoxville Ave.
691-4702, Ext. 791, 792, 793
St. Francis Hospital
530 Northeast Glen Oak Ave.
674-2943

PERU
Peoples Hospital
925 West Street
223-3300, Ext. 53, 55

PITTSFIELD
Illini Community Hospital
640 West Washington St.
285-2115, Ext. 238, 213

PRINCETON
Perry Memorial Hospital
530 E. Park Ave.
875-2811, Ext. 311

QUINCY
Blessing Hospital
1005 Broadway
223-5811, Ext. 255
St. Mary's Hospital
1415 Vermont St.
223-1200, Ext. 275

ROCKFORD
Rockford Memorial Hospital
2400 North Rockton Ave.
968-6861, Ext. 441

St. Anthony's Hospital
5666 E. State St.
226-2041
Swedish-American Hospital
1316 Charles St.
968-6898, Ext. 603

ROCK ISLAND
St. Anthony's Hospital
767-30th St.
788-7631, Ext. 725, 772

ST. CHARLES
Delnor Hospital
975 North Fifth Ave.
584-3300, Ext. 229

SCOTT AIR FORCE BASE
USAF Medical Center
256-7363

SPRINGFIELD
Memorial Hospital
First and Miller Sts.
528-2041, Ext. 333
St. John's Hospital
701 E. Mason St.
544-6451, Ext. 375

STREATOR
St. Mary's Hospital
111 E. Spring St.
672-3189, Ext. 221

URBANA
Carle Hospital
611 W. Park St.
337-3311
Mercy Hospital
1400 West Park Ave.
337-2131

WAUKEGAN
St. Therese Hospital
2615 West Washington St.
688-6470-71
Victory Memorial Hospital
1324 North Sheridan Road
688-4181-82

WOODSTOCK
Memorial Hospital for McHenry County
527 West South St.
338-2500, Ext. 232, 277

ZION
Zion-Benton Hospital,
Shiloh Boulevard
872-4561, Ext. 240

PACKAGED DISASTER HOSPITALS IN ILLINOIS
Illinois Department of Public Health
Emergency Health and Civil Defense Section

535 W. Jefferson, Springfield, Illinois
Phone: (217) 525-4659 or 4812

ALTON
St. Joseph's Hospital

ANNA
Anna State Hospital

AURORA
Copley Memorial Hospital

BELVIDERE
St. Joseph's Hospital

BENTON
Franklin Hospital

CAIRO
St. Mary's Hospital

CANTON
Graham Hospital

CARLINVILLE
Carlinville Hospital

CENTRALIA
St. Mary's Hospital

CHARLESTON
Community Memorial Hospital

CHESTER
Chester Memorial Hospital

CHICAGO HEIGHTS
St. James Hospital

DANVILLE
Lakeview Memorial
St. Elizabeth's Hospital

DECATUR
Decatur Memorial Hospital

DEKALB
DeKalb Public Hospital

DES PLAINES
Forest Hospital
Holy Family Hospital

DIXON
Dixon State School

ELGIN
Elgin State Hospital
Sherman Hospital

ELMHURST
DuPage Memorial Hospital

EVANSTON
St. Francis Hospital

FREEPORT
Freeport Memorial

GALESBURG
Cottage Hospital
Galesburg State Hospital

HARRISBURG
Harrisburg Hospital

HIGHLAND PARK
Highland Park Hospital

HILLSBORO
Hillsboro Hospital

JACKSONVILLE
Jacksonville State Hospital

JERSEYVILLE
Jersey Community Hospital

JOLIET
Silver Cross Hospital

KANKAKEE
Kankakee State Hospital
St. Mary's

LAKE FOREST
Lake Forest Hospital

LINCOLN
Abraham Lincoln Memorial Hospital
Lincoln State School

LITCHFIELD
St. Francis Hospital

MANTENO
Manteno State Hospital

MARION
Marion Memorial Hospital

MATTOON
Memorial Hospital of Coles County

McHENRY
McHenry Hospital

METROPOLIS
Massac Memorial Hospital

MONMOUTH
Monmouth Hospital

MORRIS
Morris Hospital

MURPHYSBORO
St. Joseph Memorial Hospital

NORMAL
Brokaw Hospital

OAK FOREST
Oak Forest Hospital

OAK LAWN
Christ Community Hospital

OTTAWA
Ryburn Hospital

PARIS
Paris Hospital

PEKIN
Pekin Memorial Hospital

PEORIA
St. Francis Hospital

PONTIAC
St. James Hospital

PRINCETON
Perry Memorial Hospital

QUINCY
St. Mary's Hospital

RED BUD
St. Clement's Hospital

ROCKFORD
Swedish-American Hospital

RUSHVILLE
Sara D. Cubertson Hospital

ST. CHARLES
Delnor Hospital

SANDWICH
Sandwich Community Hospital

STERLING
Community General Hospital

URBANA
Carle Hospital

WAUKEGAN
St. Therese

WATSEKA
Iroquois Hospital

WINFIELD
Central DuPage Hospital

WOOD RIVER
Wood River Hospital

ZION
Zion-Benton Hospital

Medical Legal Information

(Prepared by ISMS Legal Counsel, Frank M. Pfeifer)

LEGAL SERVICES OF ISMS

The Illinois State Medical Society retains a General counsel and occasionally uses the services of special counsel in implementing its various programs. Legal advice is given to the state society and its components as organizations, but is not available to individual members.

It is intended that this article give general information only; for any specific problem consultation should be had with the physician's individual attorney.

The legal department of the Society can answer specific questions propounded by officers of county medical societies in Illinois, which are part of and make up the state society, if the questions are of interest to the membership as a whole.

Although the Society and its counsel cannot provide personal advice to ISMS members, it is to every physician's advantage to acquaint himself with as much general medical-legal knowledge as possible. The following section, therefore, is devoted to this kind of information.

HOW TO SET YOUR AFFAIRS IN ORDER

It is suggested that the physician, during his lifetime, compile in one place needed information about the location of important records and papers. The Illinois State Medical Society urges that a will be prepared by a competent attorney and said will be re-evaluated by an attorney whenever there is a material change in any circumstances or in state law.

The physician should, of course, leave information about insurance, real estate, and bank accounts just as everyone else does, but he has additional responsibilities peculiar to his profession. He should leave instructions for:

1. Temporary coverage of his practice. Some arrangement with a colleague should be made immediately for hospitalized patients, and others should be notified of the doctor's death.

2. Patient records, which should be carefully preserved for a minimum of 10 years and for 25 years, if possible. Contents of the records should be turned over to another physician upon written request.

3. Return of unused narcotics to the Treasury Department, the narcotics tax stamp and order book to the Internal Revenue Service, and retention of the narcotics ledger for two years.

4. Disposal of his practice. If it is to be sold, rapid action is advised as value is lost quickly. Equipment is best disposed of with the sale of the practice.

5. Benefits that may be due survivors from unused insurance premiums, Blue Cross-Blue Shield, Veterans Administration, or Social Security.

As soon as practical after death, the attorney who will handle the estate should be contacted and his advice followed thereafter.

LEGAL LIABILITY OF PHYSICIANS

The legal liability of physicians is a question on which much has been written. It has also been the topic of discussion at many meetings of medical and medical-legal groups. However, because of the grave nature of the problem, the Illinois State Medical Society's legal counsel believes that the subject cannot be overemphasized.

Statistics prove that the number of malpractice and general liability suits against physicians is on the increase. This does not mean that physicians are becoming less skillful or more careless in their diagnosis and treatment; it probably means that physicians are being affected by the tremendous growth there has been recently in all types of personal injury litigation.

More people than ever before are receiving medical attention and more are starting lawsuits against physicians when recovery is less than complete.

Liability Insurance

For this reason, it is essential that every physician carry liability insurance to protect him against all possible claims. The physician should be aware, however, that there are some inadequate policies on the market today and an attorney should be consulted before contracting for insurance that may not cover the doctor's particular circumstance. Additional coverage insofar as limits are concerned is relatively inexpensive and should be carried in sufficient amount to cover all possibilities.

Prior to the 1967 Session of the General Assembly of Illinois, the greatest recovery that could be had for wrongful death was $30,000 but this limitation has now been removed and there is no limit in the amount which may be recovered in the case of wrongful death. This means that in malpractice cases resulting in death, the verdict could be extremely high. It is therefore recommended that all physicians take a look at their malpractice insurance policies to determine that they are properly covered and in adequate limits. The cost of this insurance does not materially increase with the increase in limits and therefore extremely high limits are suggested.

A physician today is a "sitting duck" for a lawsuit even though he may in no way be guilty

of negligence. The defense of a malpractice case, even though the physician is blameless, is time-consuming and costly.

Legal implications in this field are wide, but basically the physician is liable for his own negligent acts and the negligent acts of all his employees. In the case of a partnership, he is also liable for the negligent acts of his partners.

While the right kind of insurance in sufficient amount will protect the physician financially, steps should be taken by all doctors to help minimize the filing of lawsuits of this kind and to work for reduction in the number of guilty verdicts being obtained.

The American Medical Association has prepared, and has available for distribution, several interesting pamphlets and papers on this subject. The pamphlet entitled, "Professional Liability and the Physician," reprinted from the February, 1963 issue of the *Journal of the American Medical Association,* contains this statement:

Physician's Responsibility

"In the final analysis, the physician himself must share the responsibility for the continuing existence of the unpleasant professional liability situation. Many physicians have been satisfied to pay their professional liability insurance premiums and thereafter to sit back complacently, doing nothing until they become a target. Every physician must be brought to realize that this money payment is only part of his insurance program; a much more important part is his contribution of time, study, and attention to put into effect all possible measures to safeguard the patient, himself, and his colleagues. Professional liability is in no sense merely an insurance problem. It is a medical problem and must be combatted by members of the medical profession."

The AMA phamphlet goes on to say that "prevention is the best possible defense against claims and suits" and lists these 20 prevention "commandments":

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.

2. The physician must know and exercise his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician must keep records which clearly show what was done and when it was done, which clearly indicate that nothing was neglected, and which demonstrate that the care given met fully the standards demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.

5. A physician must avoid making any statement which constitutes, or might be construed as constituting an admission of fault on his part. He should instruct employees to make no such statements.

6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.

7. The physician must refrain from over-optimistic prognoses.

8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.

9. The physician must unfailingly secure an "informed" consent (preferably in writing) for medical and surgical procedures and for autopsy.

10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.

11. The physician should limit his practice to those fields which are well within his qualifications.

12. The physician must frequently check the condition of his equipment and make use of every available safety installation.

13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment.

14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.

15. The physician should not sterilize a patient solely for the patient's convenience except after a reasonably complete explanation of the procedure and its risks and possible complications and after obtaining a signed consent from the patient and from the patient's spouse if the patient is married. Such sterilization is a crime in Connecticut, Kansas, and Utah and should not be performed in those states. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may lawfully be performed with the informed consent of the patient and preferably with the informed consent of the patient's spouse, if the patient is married.

16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes, and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

The general counsel for the Illinois State Medical Society has given the following suggestions on how to avoid and defeat malpractice suits:

1. Physicians should conduct their practice in hospitals so that they comply with and live up to the standards for hospital accreditation of the American Hospital Association, the hospital regulations adopted by the State Department of Public Health under the Hospital Licensing Act and the by-laws of the hospital in which they are practicing.

2. Physicians should keep up on modern medicine in the fields in which they practice so they are conversant with and use the latest proven developments.

3. Physicians should call in specialists whenever the need arises.

4. Physicians should provide for automatic consultation in all serious cases—it cannot be disputed that any physician being called on to defend his treatment in court is in a much better position if he can also bring forth as a witness the physician who reviewed the case and consulted with him, or the specialist in a given field called in by him.

5. Hospital records and those of the physician should be kept in such manner and in such detail as will be meaningful and show that adequate medical procedures were followed. It should be remembered that frequently cases are not filed until some time after the alleged injury took place and sometimes do not come to trial for several years thereafter.

6. All cases should be treated in such a manner and records kept as if the case would result in a malpractice suit and would not come to trial for a considerable period of time after the alleged injury had taken place.

7. Physicians should carry adequate malpractice insurance.

The Illinois State Medical Society has published a pamphlet, "The Physician's Liability in Patient Care," which is available for distribution to any physician who does not have a copy and desires one.

Consent by Minors to Medical Treatment and Operations

The general law in Illinois is that a minor cannot give legal consent or waive any rights which he has under the law. In the year 1961, the Illinois legislature made an exception to this rule by specifically providing that consent to the performance of medical or surgical treatment by a licensed physician could be executed by a married person who is a minor or a pregnant woman who is a minor and shall not be voidable because of such minority. This act further provides that any parent who is a minor may consent to the performance upon his or her child of medical or surgical procedures by a licensed physician and that the consent shall not be voidable because of such minority.

In the year 1969, the Illinois legislature made further exception to this rule by providing that:

1. Anyone 18 years of age or older may give binding legal consent to all medical and surgical procedures. (Consent for all operations or any unusual, improper or dangerous medical procedures should be in writing regardless of age.)

2. It is no longer necessary for either hospital or physician to obtain consent from parent or guardian before rendering emergency treatment to a minor, if the obtaining of the consent might adversely affect the condition of the minor's health.

3. Anyone over the age of 18 years may donate blood without the consent of parent or guardian.

4. Any minor 12 years of age or older having a venereal disease may now give consent to the furnishing of medical care related to the diagnosis or treatment of such disease. All such cases shall be reported by the physician to the State Department of Public Health or the local Board of Health. Any physician providing diagnosis or treatment for a minor having a venereal disease may in his discretion inform the parent or guardian of such minor as to the treatment given or needed.

5. Physicians are now specifically authorized to provide birth control services including medical and pharmacological treatment and information to any minor:

a) who is married; or
b) who is a parent; or
c) who is pregnant; or
d) who has the consent of his parent or legal guardian; or
e) as to whom the failure to provide such services would create a serious health hazard; or
f) who is referred for such services by a physician, clergyman or a planned parenthood agency.

Employment Contract Between Physician and Patient

The relationship between a physician and a patient is one of contractual relationship and, therefore, a physician is under no legal requirement to accept anyone as a patient unless he so desires. This rule is true in the case of an

emergency even though no other physician is available.

Legally, a physician has the right to refuse treatment in the case of an accident or other emergency and could not in any way be held liable for refusing to administer aid. (*This is strictly the legal answer and does not involve the moral or ethical question.*) The rendering of such services as may be necessary in the case of an emergency does not of itself give rise to the relationship of physician and patient and the physician is under no obligation to continue treatment beyond the emergency.

The physician in rendering emergency treatment, however, must use the same degree of skill and care as required in other cases, taking into consideration conditions at the scene of the accident.

Continuation of Treatment

A physician or surgeon, on undertaking an operation or treatment, is under the duty, in the absence of an agreement limiting the service, of continuing his attendance, after the operation or first treatments, as long as the case requires attention; and a surgeon, in his treatment subsequent to an operation, is required to exercise reasonable and ordinary skill and care.

The failure to give needed continued care under an obligation to do so constitutes negligence or malpractice. The obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship of physician and patient, by mutual consent of the parties, by the discharge of the physician by the patient, or by the physician's withdrawing from the case after giving the patient reasonable notice so as to enable him to secure other medical attendance.

A physician has the legal right to withdraw from a case if the patient breaks the contract by failure to follow the medical advice or treatment and direction of the physician, but the relationship cannot be terminated until the physician has advised the patient of his withdrawal from the case and has allowed the patient a reasonable length of time to procure another doctor.

Written Notice

What is reasonable notice to the patient depends upon the circumstances of each case. Factors which must be taken into consideration are the condition of the patient, the size of the community, and the availability or other physicians. In order to be completely safe, prior to withdrawal from the case, the physician should advise the patient in writing of his intent to withdraw, his reasons therefor, and the fact that he will make available the patient's case history and information regarding diagnosis and treatment to the new physician when selected by the patient. Should the patient return to the original physician stating that he has been unable to procure other medical aid, treatment should not be refused until a replacement has been obtained.

A physician has the right to leave his practice temporarily if he makes provisions for the attendance of a competent physician during his absence. This notice, which again preferably should be in writing, should be in sufficient time so that patients can obtain replacements of their own choice if they do not desire to consult the physician temporarily handling the practice of the absent physician.

GOOD SAMARITAN ACT

The 1965 Legislature passed the so-called "Good Samaritan Bill" providing that any physician, who in good faith, provides emergency care without a fee at the scene of a motor vehicle accident or in case of nuclear attack shall not as a result of his acts or omissions, except in the case of gross willful or wanton negligence, be liable for damages. (Paragraph 2a of Chapter 91, Illinois Revised Statutes, 1967.)

In 1969 this Act was further amended to extend the physician's immunity to any type of accident.

HOSPITAL PATIENT RECORDS

The 1969 session of the General Assembly passed a new act which provides that all private or public hospitals shall, upon the demand of any patient, allow his physician or attorney to examine his hospital records and to make copies thereof. The only exception is in connection with records relating to psychiatric care. Demands for such records must be in writing and shall be delivered to the administrator of the hospital.

HOSPITAL EMERGENCY ROOMS

For many years Illinois law has required that both public and private hospitals, where surgical operations are performed, must provide emergency medical treatment or first aid to any person who applies for same in the case of injury or acute medical condition where the same is liable to cause death or severe injury or serious illness. This act provides penalties for noncompliance.

In the 1969 session of the Legislature this act was amended by Senate Bill 568 by allowing two or more hospitals to combine for the purpose of providing this emergency service upon an area wide or community basis but with the requirement that the plan of consolidation be reduced to writing and approved by the Illinois Department of Public Health prior to its implementation.

INTERNAL REVENUE CODE

It should be evident to the busy physician that

it is just as unwise for him to be his own tax consultant as it is for every man to be his own doctor. The physician is well aware that in seeking to keep abreast of all of the ramifications and developments of modern medicine, he has a burden that is becoming increasingly difficult to sustain and that he has very little time to devote to subjects as complex as taxation, which is rightfully the province of his accountant and lawyer.

Just as the patient would be so much better served if he saw his doctor regularly before difficulties became advanced, so the physician's interests would be better served if he would seek advice on income and estate tax problems before the fact, rather than after problems have arisen.

PROCEDURES AND REPORTS AS TO COMMUNICABLE DISEASES

In order to be conversant with the presently governing rules and regulations as to the control of communicable diseases and the physician's duties as to reports and procedures in relation to these afflictions, it is suggested that the physician apply to the Department of Public Health of the State of Illinois at Room 500, State Office Building, Springfield, for the publication entitled, "Rules and Regulations for the Control of Communicable Diseases."

ANATOMICAL GIFT ACT

The law, in the State of Illinois, allows an individual to leave his body or particular parts thereof, for medical science by means of his will or a written statement carried upon his person or found among his effects. The next of kin may also donate all or any part of the body for medical science. The Illinois law, authorizing the above, is set out at Paragraphs 551 through 560 of Chapter 3, Illinois Revised Statutes, 1969.

The Illinois State Medical Society has prepared forms which may be used by both the donor himself or by the next of kin. Copies of these forms are available at headquarters office in Chicago.

Anatomical Gift By a Living Donor

(1)
I, ..., do hereby give
(2)
..... to
(3)
..... for the following
(4)
purpose:

.....

IN WITNESS WHEREOF, I have hereunto set
(5)
my hand and seal this day of, A.D. 19———.
(6)
.....(SEAL)

Signed, sealed, published and declared by the
(1)
said in the presence of us, who at his (her) request, in his (her) presence and in the presence of each other have hereunto subscribed our names as attesting witnesses, believing him (her) to be of sound and disposing mind and memory, free from any undue influence, and to know the objects of his (her) bounty and affection.
(7)
.....
(7)
.....

Instructions

1. Insert name of person making gift.
2. Insert: "my whole body"; or list specific organs and parts to be given.
3. Insert name and address of a physician; or a hospital, or a medical institution to receive the gift.
4. Insert: "any purpose authorized by law;" or "a transplantation" or "therapy;" or "research;" or "medical education."
5. Insert date of the signing of this card.
6. Signature of donor.
7. Signature and address of two necessary witnesses.

Anatomical Gift by Next of Kin Or Other Authorized Person

I. I (we) are the surviving:
 1. ☐ Spouse and adult sons and daughters
 2. ☐ Both parents or surviving parent
 3. ☐ Adult brothers and sisters
 4. ☐ Guardian of the person of the decedent
 5. ☐ Person authorized or under obligation to dispose of the body

 of, who died on the day of, 19..... in the County of, State of; and

II. I (we) hereby give:
 ☐ The entire body of the deceased.
 ☐ Any specific organs or parts of the body of the deceased designated by the donee.
 ☐ The following organs or parts of the body of the deceased:

.....

TO:
(Insert name and address of a physician; a hospital; or a medical institution)
for one of the following purposes:
☐ Any purpose authorized by law.
☐ A transplantation.
☐ Therapy.
☐ Research.
☐ Medical education.

III. I (we) hereby represent and certify that I (we) are the person(s) authorized to execute this authorization in accordance with the order of priority specified in the Uniform Anatomical Gift Act as listed in #I above.

Name Relationship to deceased City & State

Instructions

This form must be signed by the survivor or survivors in the order of priority, Nos. 1 through 5, with all persons in any category being required to sign. (EXAMPLE: Form to be signed by living spouse and all living adult sons and daughters; but if no survivors in this category, then go on to No. 2 under which surviving parents or parent must sign but if no one in this category, go to No. 3, where all surviving brothers and sisters must sign; and in the same manner through Categories 4 and 5 if necessary.)

If additional signature lines are needed, they may be added at the bottom of the form.

AUTOPSY

In Illinois, the heirs and next of kin can bring an action for mutilation of the body in those cases where an autopsy is performed without authority or permission. In order to avoid the possibility of liability, autopsies should only be performed, in Illinois, when ordered by the coroner or upon written consent given by the next of kin. The coroner may order an autopsy directly against the wishes of the next of kin.

MEDICAL CORPORATIONS

In 1963 the Illinois Legislature for the first time authorized the formation of medical corporations (Paragraph 631 through 647 Chapter 32 *Illinois Revised Statutes,* 1969). Under this act one or more physicians licensed to practice medicine may organize as an Illinois business corporation. All officers, directors and shareholders of the corporation must be licensed under the Medical Practice Act.

After the passage of this Act, Internal Revenue took the position that physicians were not entitled to any tax benefits thereunder. In those cases appealed, the courts ruled that such benefits should be allowed.

In the summer of 1969 Internal Revenue retreated from this position and now is holding that medical corporations authorized under state law are valid and that the tax benefits accrue to the members.

The question as to whether or not a medical corporation is advisable depends upon each individual situation but in most instances, tax dollars probably can be saved by the formation of such a corporation. It is suggested that physicians, whether practicing individually or in a group, consult their accountants and attorneys to determine if such incorporation would be profitable.

STATUTE OF LIMITATIONS IN MALPRACTICE CASES

The Supreme Court of Illinois in the case of *Lipsey v. Michael Reese Hospital and Dr. Gerald Menaker,* (1970) handed down a decision in which the statute of limitations in malpractice cases was extended and in some instances nullified. The law in Illinois, until this decision, was that an action of malpractice was on the same footing as any other personal injury case, namely, that the law suit had to be commenced within two years after the alleged negligent act took place and if not commenced within this time the law suit was barred.

In this case the alleged negligent act was a mis-diagnosis of cancer with the discovery of the cancer occurring more than two years after the alleged mis-diagnosis. The physician and hospital moved to dismiss the case due to the fact that more than two years had elapsed since the occurrence, but the Supreme Court of Illinois followed the so-called "discovery rule" which is in effect in many other jurisdictions in the United States and held that such a case could be brought within two years after the discovery of the alleged negligent act or within two years after it should have been discovered.

The effect of this decision is that the statute of limitations is of very little effect in Illinois insofar as malpractice law suits are concerned for the suit may be brought at anytime if the allegation is that the discovery was made within two years of the date of filing suit. Since there are no longer any meaningful time limitations, it becomes more important than ever that physicians maintain adequate records and retain them during the lifetimes of their patients.

IMMUNITY FOR MEDICAL REVIEW COMMITTEES

The 1971 session of the General Assembly amended Section 2b of the "Medical Practice Act" by enlarging this immunity section to cover medical review committees and peer review committees. The language of this Section 2b is now as follows:

"While serving upon any Medical Utilization Committee, Medical Review Committee or Peer Review Committee any person licensed to practice medicine in all of its branches shall not be liable for civil damages as a result of his acts, omissions or decisions in connection with his duties on such committee, except those involving willful or wanton misconduct."

Physicians serving on medical review committees need no longer be fearful of damage suits so long as their actions do not involve willful or wanton misconduct.

General Health Services Information

Health services information not listed in this Reference Issue can be obtained by contacting the following:

The Chicago Hospital Council
840 N. Lake Shore Drive
Chicago 60611

Department of Public Health
503 State Office Building
Springfield 62706

Department of Mental Health
401 S. Spring Street
Springfield 62706

Department of Children & Family Services
Room 404, New State Office Building
Springfield 62706

Department of Public Aid
618 E. Washington Street
Springfield 62706

Department of Registration & Education
160 N. LaSalle Street
Chicago 60601

Department of Allied Medical Professions & Services
American Medical Association
535 N. Dearborn Street
Chicago 60610

Division of Vocational Rehabilitation
623 E. Adams Street
Springfield 62706

Illinois Hospital Association
840 N. Lake Shore Drive
Chicago 60611

Illinois League for Nursing
6355 Broadway
Chicago 60626

Metropolitan Chicago Nursing Home Association
43 E. Ohio Street, Suite 1206
Chicago 60611

Directories are available for the following:

Dentists

American Dental Directory. Available from the American Dental Association, 211 E. Chicago, Chicago, Illinois. Annual. $25. Lists members and nonmembers, military dentists, dental schools, associations linked to ADA, examining boards, health agencies, state dental organizations, etc. For Dentists, lists name, address, birth year, dental school, degree, specialty, etc.

Osteopaths

Yearbook and Directory of Osteopathic Physicians. American Osteopathic Association, 212 East Ohio Street, Chicago. Annual. $25 for first copy, $12.50 each additional copy. Covers both members and nonmembers, colleges, associated osteopathic hospitals. For Osteopaths, lists name, address, birth year, osteopathic school, specialty, etc.

Physicians and Surgeons

AMA Geographic Register of Physicians. AMA, 525 North Dearborn, Chicago. Every 2 years. $90. Latest volume April, 1970. Covers both members and nonmembers, colleges, etc. For Medical Doctors, lists name, address, birth year, type of practice, specialty, medical education, license year, boards passed, society memberships, etc.

Podiatrists

Desk Reference. American Podiatry Association, 3301 16th Street NW. Washington, D.C. Annual. About $25. (Free to advertisers; write "Business office".) Includes alphabetic and geographic listing of podiatrists, affiliated organizations, accredited colleges, therapeutic indices and a catalog of audiovisual, informational and educational materials. For Podiatrists, lists name, address, birth year, podiatric specialty, etc.

Drugstores

Hayes Drugstore Directory. Edward N. Hayes, Publisher, 206 West 4th Street, Santa Ana, California. Annual. $36 if buy regularly; $40 one time basis. Lists retail drugstores, estimating volume and credit rating. A list of wholesale druggists is also included.

Internships and Residencies

Directory of Approved Internships and Residencies, AMA, 525 North Dearborn, Chicago. Published in the Fall of the year. Free.

Nursing Homes

U.S. Guide to Nursing Homes. Published by Grosset & Dunlap, Inc., New York City. Each of 3 volumes covers a geographic section of U.S.; $2.95 per volume. Name and address of home, number of beds, medical services available, recreation and entertainment. (Even a section on how to tell someone they are entering a nursing home without feeling guilty. Perhaps a little too consumerish for some, but very worthwhile for the public relations of nursing homes.)

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ISMS LEADERSHIP CONFERENCE

Sunday, November 7, 1971

Continental Plaza Hotel, Chicago

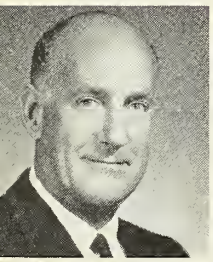
Morning Session

The Changing Face Of Health Care Delivery In Illinois

Learn about the 15 emerging HMO's in Illinois . . . where they will be located . . . how they plan to deliver health services in your area . . . what effect they'll have on your practice!

Hear what neighborhood health centers and model city programs are planning with respect to the delivery of medical programs. Should you adapt your practice to meet their needs?

Are you overworked? Does your community need more physicians? Does your hospital want to contract for ER services? Listen to what Dial-A-Doctor, Physicians-On-Call and Comprehensive Medical Associates have to offer!



Dr. Annis

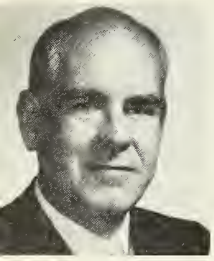


Dr. Sammons

Afternoon Session

IS AMA in Step With the Times?

Hear critics challenge a distinguished panel of AMA spokesmen—Drs. Russel Roth, James Sammons and Edward Annis—on AMA policies, actions, etc. Dan Price, host of Radio Station WGN's "Extension 720," will moderate the panel.



Dr. Roth



Dan Price

I will attend the Leadership Conference November 7, 1971, at the Continental Plaza Hotel in Chicago. Enclosed is my check for $..... covering lunch(es) ($6.00 per person).

Name

Address

City Zip

Mail to: Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Illinois 60601

A Review of Illinois'

Clinical Laboratories and Blood Banks

By Paul A. VanPernis, M.D./Rockford

The Illinois Department of Public Health is charged under the Illinois Hospital Licensing Act and the Illinois Clinical Laboratory and Blood Bank Licensing Acts with surveillance of all laboratories and blood banks except those operated by licensed physicians who do laboratory work on only their own patients. In addition, independent laboratories may voluntarily be certified under the Medicare Acts in order to receive payment for laboratory procedures under this system. Laboratories receiving specimens in interstate commerce must be licensed or exempted under the federal Clinical Laboratory Improvement Act. Blood Banks must be federally licensed if they wish to receive or send blood or blood components across State boundaries.

Laboratories may voluntarily be inspected and accredited under the College of American Pathologists system and Blood Banks may similarly be approved by the American Association of Blood Banks. The Joint Commission on Hospital Accreditation inspects and approves only hospital laboratories and blood banks. The Red Cross inspects and approves Red Cross Blood Banks although they may voluntarily be approved under the American Association of Blood Banks Plan. Red Cross blood banks in Illinois must be licensed under the Illinois State Program.

In addition to the on-site inspection programs just mentioned, the Illinois Clinical Laboratory and Blood Bank Licensing Acts require participation in testing designed to measure the proficiency of laboratories and blood banks. These are programs operated by the Illinois Department of Health or programs approved by that agency since the State Health Department lacks funding and trained personnel to operate a sufficiently inclusive program of testing.

Statistics given in this summary were obtained from the Illinois Department of Health, the American Association of Blood Banks and the College of American Pathologists. Statistics from other testing services approved by the State Department of Health are not as comprehensive, are not as widely used in Illinois, and are not available.

This compilation is made to indicate the lack of uniformity in assessing the proficiency of laboratories and blood banks as well as the lack of adequate on-site inspection. At present, a physician desiring to refer patients for laboratory examinations can only determine for himself the proficiency of a laboratory by his own on-site inspection, direct contact with those per-



PAUL A. VAN PERNIS, M.D., is a Rockford pathologist and a member of numerous societies relevant to blood banks and pathology. Dr. Van Pernis has authored many articles dealing with laboratories and blood banks and has served as a consultant to various staffs on the subjects. He received his M.D. degree from Rush Medical College and did post-graduate work under Dr. Papanicoloau in cytology at Cornell University Medical School. Dr. Van Pernis is presently affiliated with Swedish American Hospital, and is a clinical associate in the Rockford Division of the University of Illinois.

Clinical Laboratories and Blood Banks

sons responsible for the testing and knowing whether or not that laboratory has evidence by certifications of their willingness to voluntarily participate in extensive proficiency testing. He must also be aware of the results of such proficiency testing.

The compilation given also indicates that proficiency testing, inspection and accreditation is not as widespread as it could be. Although no hospitals, laboratories or blood banks are named, this study reveals that university hospitals and their affiliated teaching hospitals participate least in these programs. This may be due to a self satisfied "medical center" attitude believing they are above such testing and inspections. Since it is known that such hospitals on occasion have not been able to pass a thorough inspection and testing program, it is suggested that "teaching hospitals" may need some soul searching as to laboratory direction and allocation of funds to improve their proficiency.

Certainly an increase in the attempt to make inspection, accreditation, and proficiency testing more uniform is needed. The Joint Commission on Hospital Accreditation newly revised guides are a beginning. The requirements for independent laboratories, blood banks and hospital laboratories are now uniform in Illinois. The reciprocity already established between the Illinois Department of Public Health and the American Association of Blood Banks could serve as a model for reciprocity between all of the inspection and testing agencies now acting independently.

The quality of laboratory testing must be improved in all laboratories and blood banks in Illinois including those in the large group of physicians' offices now doing laboratory procedures but not having adequate quality control.

		Hospital Laboratories	Independent Laboratories	Physician's Office
1. State Licensed		395	288	
Participation in:				
2. State Operated Proficiency Tests:				
Syphilis Tests	VDRL	227	290	71
	RPR	97	79	
	ART	1	0	
	FTA	30	33	
	Rubella HIT	33	21	
	TB culture	147	28	
	TB smear	247	144	
	Quantitative PKU	34	4	
	Guthrie Test	96	5	
3. American Association of Blood Banks Inspection and Accreditation		75	12	
4. Red Cross Banks		0	2	
5. College of American Pathologists Inspection and Accreditation		40	2	
6. College of American Pathologists Office Laboratory Proficiency Test		0	0	11
7. Certified for Payment Under Medicare		0	149	0
8. Licensed or exempt under the Federal Laboratory Improvement Act		0	10	Unknown
9. College of American Pathologists Basic Proficiency Testing Program		117	85	0

I.

A. *Basic-Specimens for the following analyses are shipped four times a year (a total of 156 tests), as follows: 2 specimens, each containing the following:*

a. & b. bilirubin, calcium, cholesterol, glucose, potassium, sodium, urea nitrogen, uric acid
c.....hemoglobin
d.....hemoglobin
e.....RBC count and hematocrit
f.....blood smear and hematocrit
g.....prothrombin time
*h.....red cell suspension
* i.....serum
* j.....serum
k.....diagnostic immunology
l.....parasite identification
m.....bacteria identification
n.....urine specimens for: hemoglobin, specific gravity, protein, reducing substance, bilirubin

**h, i, j are tests for ABO, Rh, crossmatch*

10. College of American Pathologists Comprehensive program	Hospital Laboratories	Independent Laboratories	Physician's Office
B	83	3	0
C	108	18	0
H	109	13	0
J	116	14	0

II. Comprehensive

B. *Comprehensive Bacteriology-Mycobacteriology-Parasitology-Mycology-Serology Series:* Specimens for the following analyses will be shipped four times a year (a total of 40 tests), as follows:

a.....bacteria identification
b.....bacteria identification
c.....mycrobacteria identification
d.....mycobacteria identification
e.....fungus identification
f.....fungus identification
g.....parasite identification—blood smear
h.....parasite identification
i.....immunology specimen
j.....immunology specimen

C. *Comprehensive Chemistry Series*—Each of the four series contains two unknown samples to be tested for the listed constituents, (a total of 144 tests), as follows:

a. & b. bilirubin, calcium, chloride, cholesterol, glucose, potassium, SGOT, sodium, urea nitrogren, uric acid, phosphorus, protein-bound iodine or T-4 by column, creatinine, total protein, triglyceride, serum iron

NOTE: A test for Lithium will be included in series C-A and C-C and a test for Magnesium will be included in series C-B and C-D.

Clinical Laboratories and Blood Banks

H. *Comprehensive Hematology Clinical Microscopy Series*—Specimens for the following analyses will be shipped four times a year (a total of 84 tests), as follows:

a. hemoglobin
b. hemoglobin
c. fibrinogen
d. prothrombin
e. prothrombin
f. partial thromboplastin
g. peripheral smear for differential
h. 35 mm. transparency
i. 35 mm. transparency
j. 35 mm. transparency
k. 35 mm. transparency
l. RBC count and hematocrit (Normocytic)
m. WBC count
n. Urine specimen for:
specific gravity
protein
glucose
osmolarity
bilirubin
hemoglobin
o. 35 mm. transparency (urine)

J. *Comprehensive Blood Bank Series*—Developed in conjunction with the American Association of Blood Banks. In addition, AABB reference laboratories validate the specimens used in this series. Specimens for the following analyses will be shipped four times a year (a total of 153 tests), as follows:

a. & b.....2 Donor Red Cells
c. & d.....2 Donor Serums
e.....1 Recipient Red Cell
f.....1 Recipient Serum

Participants will test for ABO, Rh, antibodies in serum and perform crossmatches listed above.

11. College of American Pathologists	Hospital Laboratories	Independent Laboratories	Physician's Office
Special Testing Program—D	18	2	0
E	7	0	0
F	16	0	0
G	10	1	0
P	17	1	0
S	15	0	0

III. Special

D. *Special Bacteriology Series*—Each series contains the following specimens to be shipped four times a year (a total of 20 tests), as follows:
a.....bacteria identification
b.....bacteria identification
c.....bacteria identification
d.....bacteria identification
e.....bacteria identification

E. *Special Mycobacteriology Series*—Each series contains the following specimens to be shipped four times a year (a total of 20 tests), as follows:
a.....mycobacteria identification
b.....mycobacteria identification
c.....mycobacteria identification
d.....mycobacteria identification
e.....mycobacteria identification

F. *Special Mycology Series*—Each series contains the following specimens to be shipped four times a year (a total of 20 tests), as follows:
a.....fungus identification

b.....fungus identification
c.....fungus identification
d.....fungus identification
e.....35 mm. transparency

G. *Special Syphilis Serology Series*—Each series contains the following specimens to be shipped four times a year (a total of 80 tests), as follows:

Participants will receive 20 samples each quarter for serologic syphilis testing.

P. *Special Parasitology Series*—Each series contains the following specimens to be shipped four times a year (a total of 24 tests), as follows:
a.....parasite identification—blood smear
b.....parasite identification
c.....parasite identification
d.....parasite identification
e.....parasite identification
f.....parasite identification

S. *Special Diagnostic Immunology Series*—Each series contains the following specimens to be shipped four times a year (a total of 32 tests), as follows:
a. ASO titer
b. ASO titer
c. Infectious Mono
d. Infectious Mono
e. R.A. factor
f. Urine Pregnancy Test
g. Rubella
Antibody
h. Quant. Immunodiffusion

Malpractice panic!

In my adopted country, the U.S.A., the attitude within the medical profession to the malpractice situation verges on panic. The most prevalent attitude is that the public has little understanding of the difficulties the doctor has to face in keeping up with the developments in medicine—and that this is compounded by the rapacity of trial lawyers who, on the basis of the contingency fee arrangement, hope to make huge sums on medical malpractice cases. Another allegedly crucial factor is that insurance companies are discontinuing coverage for medical malpractice. Several cases have been settled for very large sums, the largest quoted, in Florida, being one and a half million dollars.

A survey conducted some years ago showed that a few doctors in each state did not carry malpractice insurance. Some of these men were either retired or engaged in part-time practice or possibly have been involved in law suits earlier in their careers and were thus unacceptable to the insurance companies. Others simply did not take out insurance, disagreeing with the prevailing philosophy and not accepting the principle that they should pay out large premiums to protect against an unlikely eventuality. What has happened to these hardy souls? Not very much, since most doctors never get sued, and, of those actions brought, most are settled out of court for relatively modest sums. There is certainly no epidemic of bankruptcy among doctors; those who have suffered financial disasters are more likely to have been injured by the stock market than by angry or unappreciative patients. (Michael F. Cleary: Personal View. **British Medical Journal** (May 29) 1971, page 522.)

the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

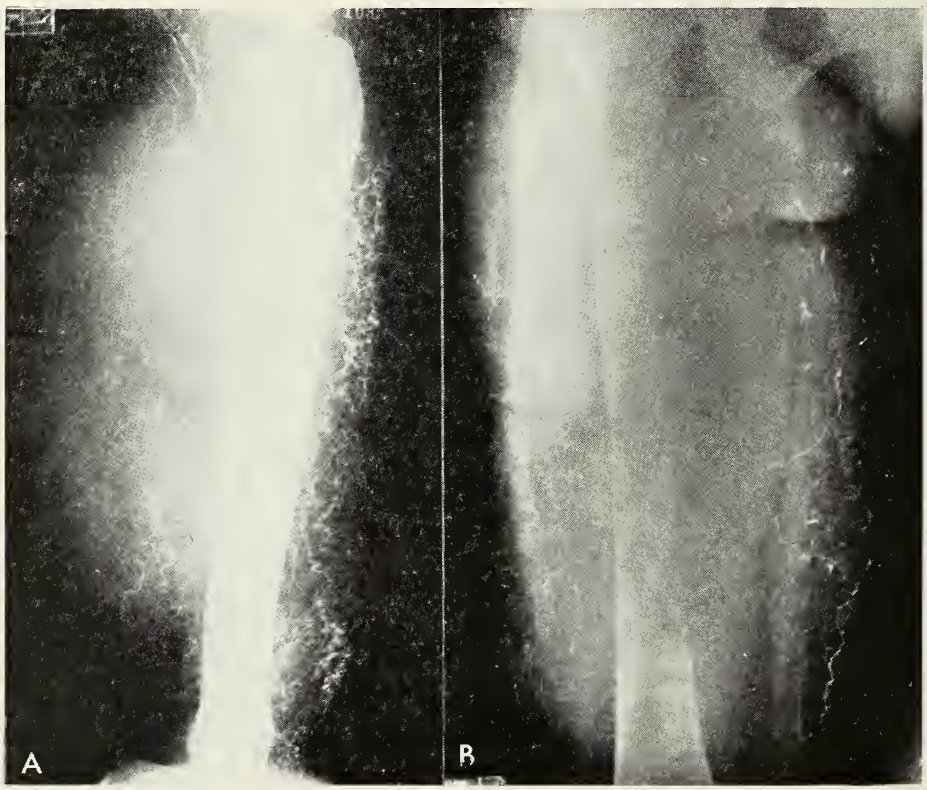


Fig. 1

There are two types of lymphedema, one is known as primary and the other is secondary. Figure 1 (a) and (b). What's your diagnosis?

(Answer on page 438)

Technique for early diagnosis Of breast cancer developed



A technique for aiding in the early detection of breast cancer has been introduced by Diagnostic, Inc. The company expects that the new Breast Pap Smear Kit may eventually make a "Pap" test for breast cancer as routine a part of a physical examination as the "Pap" test for cervical cancer is now.

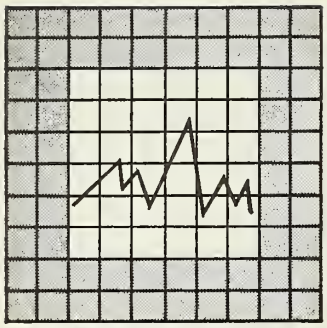
By using the Breast Pap Smear Kit, physicians can extract secretions from the breast and determine whether there are any indications of cancerous conditions. Once the secretions are obtained, the physician follows the same procedure that he does with cervical Pap smears.

The kit contains: two disposable syringes; two disposable devices (assembled, including plastic tubing and cutoff clips); two cotton pledgets saturated with cleansing solution for nipples; and four specially prepared microscopic slides in mailing envelope.

The need for a simple, inexpensive aid for reliable early diagnosis of breast cancer is great. Breast cancer accounts for the greatest share—23%—of cancer among women. The probability of a woman developing breast cancer is one in 17.

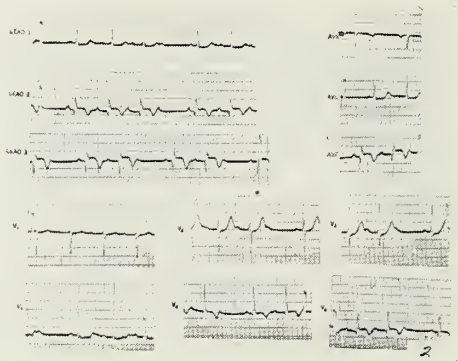
"This year, about 70,000 women in the United States will be diagnosed as having breast cancer," said Dr. Otto W. Sartorius, Santa Barbara, Calif., inventor of the breast fluid extraction device. Breast cancer mortality has been unchanged for 35 years. For women 25 years and older, breast cancer mortality has been close to 40 per 100,000 women. Because of the large number of women who develop breast cancer, even a small increase in survival rates means longer life to many women. Many experts believe that the best means of decreasing mortality rates is to improve early diagnosis systems which, like the Breast Pap Smear Kit, can detect the disease before the appearance of lumps or discharges.

"In much the same manner that cytological (cell) screening has made cancer of the cervix a controllable disease, many clinicians and investigators are reappraising the role of cytology in breast secretions," Dr. Sartorius said.



ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D.
and Patrick Scanlon, M.D./Section of Cardiology,
Department of Medicine
Loyola University Stritch School of Medicine



A 39-year-old laborer presented to the emergency room with sudden onset of epigastric pain associated with nausea and vomiting. The week prior to admission he had experienced mild retrosternal discomfort when hurrying to catch the bus to work. On examination he appeared to be in no acute distress. Blood pressure was 110/70. Pulse was 80 and irregular. The examination of heart and abdomen was unremarkable.

Questions (One or more choices may be correct.):

1. The electrocardiogram shows:
 - A. Sinus arrhythmia
 - B. Complete AV heart block
 - C. Second degree a-v block Mobitz type I (Wenchebach type)
 - D. Acute inferolateral wall myocardial infarction
 - E. Acute pericarditis
2. The treatment of choice is:
 - A. Admission to Coronary Care Unit with constant monitoring of the electrocardiogram.
 - B. Emergency insertion of a transvenous pacemaker and pacing at a rate of 85 beats per minute.
 - C. Insertion of a permanent transvenous pacemaker
 - D. Atropine 0.5 to 1 mg. IV as needed to maintain the ventricular rate above 60 beats per minute.
 - E. Rapid digitalization.

(Answer on page 432)



new pharmaceutical specialties

by paul dehaen

Single Chemicals—Drugs not previously known, including new salts.
Duplicate Single Products—Drugs marketed by more than one manufacturer.
Combination Products—Drugs consisting of two or more active ingredients.
New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

New Single Chemicals

LIDEX Hormones-Corticoids ℞
Manufacturer: Syntex
Nonproprietary Name: Fluocinonide
Indications: Adjunctive therapy for relief of inflammatory manifestations of acute and chronic corticosteroid responsive dermatoses.
Contraindications: Vaccinia and varicella. History of hypersensitivity to any of the components. Safety in pregnancy not established.
Dosage: Small amount massaged into affected area 3 or 4 times daily.
Supplied: Cream, 0.05%

Duplicate Single Products

PRO-BUMIN 5%, 25%
NORMAL SERUM
ALBUMIN (HUMAN)
USP Biological ℞
Manufacturer: Lederle
Nonproprietary Name: Phenoxymethyl penicillin (Human)
Indications: 5%—emergency treatment of hypovolemic shock following trauma, hemorrhage, burns 25%—when plasma loss is predominant
Contraindications: If shock is due to loss of whole blood
Dosage: Determined by extent of hypovolemia
Supplied: 5%—250 cc/vial 500 cc/vial 25%—50 cc/vial

ROBICILLIN VK Antibiotic Penicillin ℞
Manufacturer: Robins
Nonproprietary Name: Phenoxymethyl penicillin potassium
Indications: To treat mild to moderately severe infections due to penicillin—G sensitive organisms.
Contraindications: Used with caution on individuals with histories of significant allergies and/or asthma.
Dosage: Determined according to sensitivity of the causative microorganisms.
Supplied: Tablets, 250 mg. (400,000 units) 500 mg. (800,000 units)

Combination Products

CONTIQUE
ARTIFICIAL TEARS Eye Preparations O-t-c
Manufacturer: Alcon
Composition: Polyvinyl alcohol 2% Benzalkonium chloride 0.01%
Indications: Dry eyes and irritation associated with wearing contact lenses.
Contraindications: None mentioned
Dosage: One or two drops in eye(s) t.i.d.
Supplied: Bottles with dropper, ½ fl. oz.

GERIPLEX-FS Vitamins-Geriatric O-t-c
Manufacturer: Parke-Davis
Composition: Each 30 cc contains: Thiamine hydrochloride 1.2 mg., Riboflavin-5′ phosphate sodium 1.7 mg., Pyridoxine hydrochloride 1 mg., Cyanocobalamin 5 mg., Niacinamide 15 mg., Ferric ammonium citrate, green 15 mg. Ethylene oxide and propylene oxide polymers 200 mg.
Indications: Geriatric vitamin tonic with iron and a fecal softener
Contraindications: None mentioned
Dosage: Two tbs. daily
Supplied: Liquid

New Dosage Forms

NILSTAT Oral
Drops Fungicides-Topical ℞
Manufacturer: Lederle
Nonproprietary name: Nystatin
Indications: **Candida** (monilia) **albicans** infections of the oral cavity.
Contraindications: Hypersensitivity to the drug
Dosage: Infants: 2 cc q.i.d. (1 cc in each side of mouth) Children and adults: 4-6 q.i.d. (½ of dose in each side of mouth, retaining as long as possible before swallowing)

new pharmaceutical specialties

Supplied: Liquid, each cc contains 100,000 units

NILSTAT Topical Ointment ℞

Manufacturer: Lederle

Nonproprietary name: Nystatin

Indications: For the treatment of cutaneous or mucutaneous mycotic infections caused by Canida species (Monilia)

Supplied: Tube 15 gm., 100,000 units/gm.

ROBICILLIN VK Antibiotic Penicillin ℞

Manufacturer: Robins

Nonproprietary name: Phenoxymethyl penicillin potassium

Indications: To treat mildly to moderately severe infections due to penicillin-G sensitive organisms.

Contraindications: Used with caution on individuals with histories of significant allergies and or asthma.

Dosage: Determined according to sensitivity of the causative microorganisms.

Supplied: Oral solution, 5 cc contains 200,000 or 400,000 units.



report

a service of the american association of medical assistants, illinois society

A door is opened to the medical assistant

By Norma Domanic, First Vice President
American Association of Medical Assistants, Illinois Society

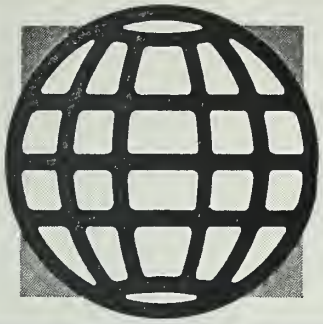
Are you a 9 o'clock to 5 o'clock girl willing to remain as you are today, or do you want to step forward in this ever-changing progressive profession in medicine?

Take a good look at yourself; are you satisfied with what you see? For the medical assistant who wants to step forward and increase her knowledge, a door is opened to you through the American Association of Medical Assistants.

Our main purpose or aim is *education*. We are a non-profit, non-union organization. As you know, physicians must continue with their education and keep abreast of all the current changes. As a member of the medical team, education is important to you, so you may be more effective in performing your duties. There is a constant change in nursing, laboratory, X-ray, office procedures, updating your billing and techniques.

Membership is tri-level, local, state and national. On the local level monthly educational meetings and workshops are offered. At the present time we have 21 county chapters. They are: Adams, Champaign-Urbana, Chicago, Northwest Cook County, Cook County South, DeKalb, DuPage, Kane, Lake, LaSalle, Macon, McHenry, McLean, Madison, Peoria, Rock Island, St. Clair, Sangamon, Tazewell, Vermilion and Will-Grundy. New chapters are being formed in Stephenson and Williamson. If you live in or near any of the above, don't miss this worthwhile opportunity. JOIN! If you don't live in or near any of the above counties mentioned, you can belong as a member-at-large. You would be eligible to attend all meetings on both state and national level and receive all educational publications. State offers symposiums, workshops, conventions and our publication *Illini Cardinal*. National offers a very fine hospitalization insurance plan through membership.

If you wish futher information please contact Mrs. Norma Domanic, 150 Ash Street, New Lennox, Ill. 60451 or Mrs. Vivian Kraft, R.R.2, Normal, Illinois, 61761.



socio-economic news

a service of the division of health care delivery

By Joseph J. Lotharius

ILLINOIS MDs INVITED TO JOIN STATE FMC

Every ISMS physician was invited to become a charter member of the Illinois Foundation for Medical Care (IFMC) in a recent mail campaign. IFMC board members urged their colleagues to accept the invitation because of the many changes threatening health care delivery throughout the state.

A strongly supported IFMC gives that organization "more clout" when negotiating with government and other third parties for statewide FMC sponsored programs. In those counties having affiliated foundations, IFMC membership is contingent upon membership in the local foundation.

RESERVE NOV. 7 TO ATTEND ISMS LEADERSHIP CONFERENCE

The changing faces of health care delivery in Illinois and how a strong AMA can help physicians cope with these changes will be discussed at ISMS' Leadership Conference on November 7. The Conference brings together key spokesmen from AMA, health maintenance organizations, hospitals, neighborhood health centers, model city programs and commercial organizations to present the various alternatives facing MDs today into clear perspective. Physicians are urged to register early to attend this important Conference. Complete the convenient registration form on page 416 NOW!

ILLINOIS PHYSICIANS NUMBER 15,299

There are 15,299 physicians in Illinois (as of Dec. 31, 1970) according to recently compiled AMA statistics. Of the total physicians, 13,182 are involved in patient care including 9,487 in office based practices, 696 serving internships, 1,916 residents and 1,083 on hospital staffs. Those physicians involved in other professional activities include 189 in teaching positions, 485 in administration, 480 doing research and 107 listed in other allied activities. ISMS membership roles presently list 10,503 physicians.

CHAMPUS RATES NO. 1

At least one government program—CHAMPUS (Civilian Health & Medical Program of the Uniformed Services)—pays physicians on a usual and customary fee basis up to

the 90th percentile of billed charges. CHAMPUS officials have told ISMS that their program has adequate federal funding and is capable of processing and paying claims within three weeks. Such statistics certainly qualifies CHAMPUS as the most desirable government program for physician participation. The other two major governmental programs, Medicare and Medicaid, are poor second choices from both the fees and claims payment standpoints.

MDs MUST SUPPLY TAX I.D. NUMBERS

Physicians must supply their tax identification numbers (social security numbers) upon request to insurance companies or federal and state programs paying them $600 or more in one calendar year (since Jan. 1, 1971). According to Internal Revenue Service regulations, this information must also be provided to unions and employers having self-insured or self-administered health care plans. IRS says these payers of health care require this information for completing tax forms.

Clinics for crippled children for November

Twenty-seven clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The Division will hold 22 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be four special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

Nov. 2—Belleville—St. Elizabeth's Hospital
Nov. 2—Fairfield—Fairfield Memorial Hospital
Nov. 3—Hinsdale—Hinsdale Sanitarium
Nov. 4—Sterling—Community General Hospital
Nov. 4—Springfield—St. John's Hospital
Nov. 4—Macomb—McDonough District Hospital
Nov. 4—Effingham—St. Anthony Memorial Hospital
Nov. 4—West Frankfort—UMWA Union Hospital
Nov. 5—Chicago Heights Cardiac—St. James Hospital
Nov. 9—East St. Louis—Christian Welfare Hospital
Nov. 9—Pittsfield—Illini Community Hospital
Nov. 9—Peoria—St. Francis Children's Hospital
Nov. 10—Champaign-Urbana—McKinley Hospital
Nov. 10—Joliet—St. Joseph's Hospital
Nov. 16—Rock Island Area General—Moline Public Hospital
Nov. 16—East St. Louis—Christian Welfare Hospital
Nov. 17—Springfield Pediatric Neurological—Diocesan Center
Nov. 17—Centralia—St. Mary's Hospital
Nov. 17—Rockford—St. Anthony Hospital
Nov. 17—Evergreen Park—Little Company of Mary Hospital
Nov. 18—Decatur—Decatur Memorial Hospital
Nov. 18—Elmhurst Cardiac—Memorial Hospital of DuPage County
Nov. 19—Chicago Heights Cardiac—St. James Hospital
Nov. 22—Peoria Cardiac—St. Francis Children's Hospital
Nov. 23—Peoria—St. Francis Children's Hospital
Nov. 24—Elgin—Sherman Hospital
Nov. 30—Alton—Alton Memorial Hospital



practice management

The Medical Corporation as a Tax Shelter

By Robert P. Revenaugh/Professional Business Management, Inc.

The medical corporation seems to be replacing the Cadillac as a status symbol of financial success. Having worked closely with the business side of physicians' practices over many years I have learned that symbols can be most deceiving. But the medical corporation represents a valid economic remedy for the large tax bite out of a successful practice. At present it is not unusual for a physician to pay more in taxes than he spends personally for food, shelter and clothing.

Except for the larger groups where the centralization of management and authority is required for progress, the motivation for incorporation is mainly economic—i.e., tax shelter. The unincorporated doctor earns income, pays tax on it (at a high rate) and then lives, makes investments, provides for retirement and pays for life, health and accident insurance premiums with the remainder. Because of this he often has difficulty in progressing financially. Even though firms such as ours help doctors organize their finances for necessary financial progress, it takes a rather tightly organized plan to produce the desired results, and all without benefit of tax relief.

Then tax shelters came upon the scene. Oil, gas, farms, citrus groves and real estate syndicates are but a few of many arrangements which would allow a doctor to, in essence, partially deduct from his income tax the money he invested. Many of these investments, however, are not without risk. Many wise doctors consider not only the tax benefits of a tax shelter but the basic investment merit as well. Except for the tax benefit, most doctors would not otherwise invest extensively in these tax shelters.

Finally there is the medical corporation which, within generous limits, allows a physician through his corporation not only to obtain a 100% deduction for his investment in a pension and/or profit sharing plan but also enables him to invest these funds almost as he wishes, speculatively or conservatively. He is also able to set aside a greater amount of money than is allowed under the widely used "Keogh Plan." In addition, the corporation might also pay a number of what once were personal insurance premiums such as life, health, accident, and sometimes medical premiums. Although incorporation usually means less spendable income to the doctor, he likewise need not spend what he does receive for a retirement investment program, disability insurance and sometimes medical and dental costs. He can also better regulate his home finances with the resultant fixed salary and maintain a stable standard of living. As an additional benefit the fixed salary generally eliminates the need for the quarterly tax estimate payments as the income and social security taxes have already been with-held from his salary.

We advise our doctors that so long as they are eligible incorporation is the best allowed tax shelter available.

It is a rather critical determination as to who is an eligible doctor. To consider incorporating, the

practice management

doctor should meet at least some of the following criteria:

Be in a high tax bracket—

Have a low number of non-professional employees—

Already be investing—

Have a sizeable insurance program—

Be able to adjust to a less spendable income—

There are also various rules of thumb used to determine eligibility. Some say you should be earning in excess of $40,000 per year; others that you should be able to save at least $3,000 per year in taxes. Still others suggest that you should be able to set aside $6,000 or $7,000 per year on your own behalf in a personal or profit sharing plan. These rules of thumb are just that. In the last analysis the benefits depend upon your individual circumstances.

Entering a corporation is not all roses. A one-man corporation may incur $1,300/year in additional, although tax deductible, expenses. There is also a certain amount of red tape involved in corporate practice. There are additional forms and taxes to the government, additional accounting and formalized minutes of meetings. However, if one is to incorporate, he must expect to operate as a corporation.

Our firm recommends incorporation only after we feel that such is the best course for the doctor. After several years of experience with medical corporations we have made several observations:

- While we were at first concerned about our doctors' families being able to adjust to less spendable income, they have, for the most part, been able to do so.
- Like marriage, the first few months are the most difficult and the first year is the most awkward. But once this time is over, if the corporation was properly established, the practice becomes fairly routine and requires less of the doctor's time for administration.
- We have been able to help them with most of the red tape problems.

In summation, we feel that, given the right doctors and the right circumstances, incorporation represents the best tax shelter available to doctors today.

ekg of the month

(Continued from page 424)

Answers:

1. *C & D.* Second degree a-v block Mobitz type I (Wenchebach type). Acute inferior wall myocardial infarction. Progressive prolongation of the PR interval is seen in successive beats until a ventricular complex drops out. Transient AV conduction abnormalities, ranging from first degree AV block to complete AV heart block are frequently seen in acute inferior wall myocardial infarction. Ischemia of the AV node is most frequently the cause for the conduction disturbance.

2. *A & D.* Patients with acute myocardial infarction should have constant electrocardiographic monitoring. Since AV conduction abnormality is most commonly transient in inferior wall myocardial infarction, as long as the ventricular response is adequate, medical management will often suffice. Intravenous atropine may be tried if the rate drops below 60 or 70 beats per minute. Digitalis should be avoided since it tends to increase AV conduction abnormalities. If adequate ventricular rate cannot be maintained with medical management or digitalis is to be used a transvenous temporary demand pacemaker should be inserted.

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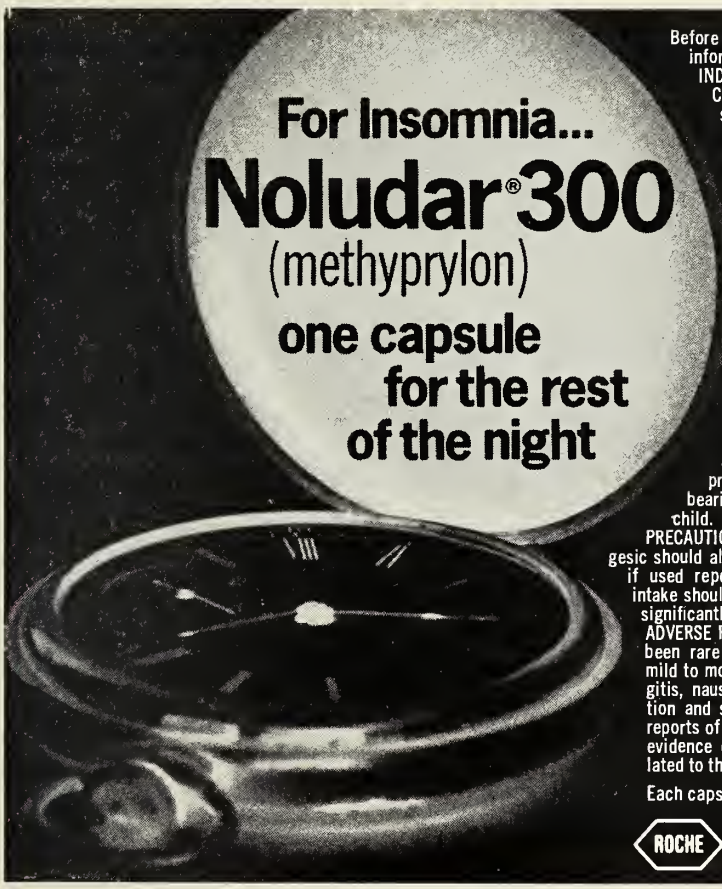
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what goes on

a guide to continuing education

October 13 and 16-17—School of Associated Medical Sciences, University of Illinois College of Medicine & South Suburban Dietitic Association

Continuing Education Program

This program implements the third phase of a continuing education plan designed to provide dietitians with an opportunity to learn more about group dynamics and how they may function more effectively as members of the health care team. For registration write: Continuing Education Section, Center for Education Development, University of Illinois College of Medicine, 835 S. Wolcott Ave., Chicago 60612.

Brinkham Hall-Christ Community Hospital-Oak Lawn, Ill.

October 20-21—Cleveland Clinic Educational Foundation

The Clinical Aspects of Liver Disease

This course will be presented by staff members assisted by guest speakers. Registration fee: $60. Acceptances will be made in the order of applications. Information write: The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland, Ohio 44106.

Bunts Auditorium, 2020 E. 93rd St., Cleveland, Ohio

October 21-23—The American College of Physicians

Diabetes—An International Review—the 50th Anniversary of Insulin

The course will cover recent advances in diabetes, emphasizing insulin treatment. Also review diabetic diets and fat-controlled diet modifications.

Myers Auditorium, Indiana State University School of Medicine

October 23-29—Abraham Lincoln School of Medicine

Otolaryngology Annual Assembly

The assembly is designed to provide specialists with a one-week experience in comprehensive review during which time, in addition to reinforcing previous learning, they will also have the opportunity to involve themselves in a consideration of the recent advances in otolaryngologic science and skills. The program will be practical and problem-based, and, in addition to lectures and demonstrations, the learner will have the opportunity for personal involvement through group discussions and seminars. For further information write: Continuing Education Section, Center for Educational Development, University of Illinois College of Medicine, 835 S. Wolcott Ave., Chicago 60612.

University of Illinois, College of Medicine-Chicago, Ill.

October 24-28—American College of Chest Physicians

37th Annual Scientific Session

Among scientific highlights will be nine major symposiums on specific problem areas in cardiovascular and pulmonary medicine; special teaching sessions; a full day clinic teaching session; special television clinics; and scientific and technical exhibits. For further information write: Alfred Soffer, M.D., Executive Director, American College of Chest Physicians, 112 E. Chestnut St., Chicago 60611.

Sheraton Hotel—Philadelphia, Penn.

October 29-30—American Medical Society on Alcoholism

Multidisciplinary Treatment of Alcoholism—The Changing Role of the Physician and the Allied Health Professionals

In addition to innovative papers by outstanding authorities in the field, workshops will consider such problems as children of alcoholics; the family; medical complications; the woman alcoholic; planning alcoholism programs; traffic safety; industrial programs; the general hospital; other drug abuse and the role of non-professionals. For further information write: Maxwell N. Weisman, M.D., Director, Div. of

Alcoholism Control, State Office Building, 301 W. Preston St., Baltimore, Md. 21201.

Thomas A. Turner Auditorium, John Hopkins University School of Medicine, Baltimore, Md.

October 27-30—College Committee on Trauma of the American College of Surgeons

11th Annual Course on Emergency Aid and Transportation of the Critically Ill and Injured

This course is for the further training of those who have completed an advanced first aid course and is aimed at the laymen who arrive first at the scene of an accident. For further information and registration write: James F. Kurtz, M.D., Box 84, Hines, Ill. 60141

Chicago Fire Academy, 558 DeKoven St., Chicago, Ill.

November 1-3 and 8-10—Mayo Clinic

Clinical Reviews

This is a program of lectures and discussions on problems of general interest in medicine and surgery. Presentations will be made by members of the staff of Mayo Clinic and the faculty of Mayo Graduate School of Medicine, departments of Anesthesiology, Dermatology, Diagnostic Roentgenology, Internal Medicine, Laboratory Medicine, Microbiology, Obstetrics and Gynecology, Orthopedics, Otorhinolaryngology, Pediatrics, Physiology, Biophysics, Psychiatry and Clinical Psychology, Surgery and Urology. Fee: $35. Be sure you indicate which session you plan to attend. Registration will begin at 8 a.m. at the Mayo Civic Auditorium.

Mayo Civic Auditorium, 1st St. and 2nd Ave., S.E., Rochester, Minn.

November 5—Bi-State Regional Medical Program Diagnostic-Demonstration Stroke Unit

A Symposium on Stroke Diagnosis

For information write: Kenneth R. Smith, Jr., M.D., Project Director St. Louis University School of Medicine, 1402 S. Grand Blvd., St. Louis, Mo., 63104

Glennon Hall, St. Louis University School of Medicine, St. Louis, Mo.

November 5-6—University of Missouri—Columbia School of Medicine

12th M.D. Day Program

The scientific program is presented as a joint effort of the medical faculties of the Universities of Oklahoma and Missouri. Planned opportunities for social interchange will include a cocktail hour and dinner, various class re-unions, a buffet luncheon, and the Missouri-Oklahoma football game. For information write: University of Missouri Columbia School of Medicine—Committee for Continuing Medical Education-M-175 Medical Center, Columbia, Missouri 65201.

Columbia, Missouri

November 7-11—Dept. of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois College of Medicine

Surgery of the Aging Face

Enrollment in the program is limited. Preference will be given to surgeons activily engaged in teaching. Advance registration is necessary. Fee: $450. Send all communications to: Continuing Education Section, Center for Educational Development, University of Illinois College of Medicine, 835 So. Wolcott Ave., Chicago 60612.

University of Illinois College of Medicine, Chicago, Illinois

November 10—The University of Chicago and the Pritzker School of Medicine

Recent Advances in Diabetes Mellitus

For information write: Frontiers of Medicine, The University of Chicago, (BH Box 451) 950 E. 59th St., Chicago, Ill. 60637 or call (312) 947-5110.

Hyde Park, Chicago, Illinois

November 10-13—Mound Park Hospital Foundation and the College of Medicine, University of South Florida

Today's Hospital Problems: An Interdisciplinary Approach

Fee: $110. Twenty accredited hours by the American Academy of General Practice if desired. This postgraduate conference will be completely comprehensive and designed for physicians who hold hospital staff leadership positions, hospital administrators, hospital trustees, and such allied personnel selected by hospital administration and division chiefs. For further information write: Postgraduate Medical Education, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla. 33701.

Tides Hotel and Bath Club, Redington Beach, Florida

November 10-11—The Cleveland Clinic Educational Foundation

Problems in Internal Medicine

For information write: The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland, Ohio 44106.

2020 E. 93rd Street, Cleveland, Ohio

November 17-19—National Society for the Prevention of Blindness, Inc.

Annual Conference

The program will include papers, panel discussions and seminars on the latest developments in detecting and combating potentially blinding eye disease; com-

munity-action eye health programs, and progress for industrial and school eye safety. For further information write: Shel Sukoff, National Society for the Prevention of Blindness, Inc., 79 Madison Ave., New York, N.Y. 10016.

The Roosevelt Hotel, New York City, New York

November 19—Diabetes Association of Greater Chicago

14th Annual Symposium on Diabetes Mellitus

The meeting will be devoted to: "Pregnancy in the Diabetic," and "Neonate of the Diabetic Mother." Enrollment is free for members of the Diabetes Assoc. for Greater Chicago or the American Diabetes Assoc., medical students, resident house staff members and nurses. Fee for non-members: $10; Dietitians: $5; except for dietetic interns and dietetic trainees. Registration must be made in advance. Inquiries write: Diabetes Assoc. of Greater Chicago, 620 N. Michigan Ave., Chicago 60611, or call (312) 943-8668.

November 15-17—Interstate Postgraduate Medical Association of North America

56th Annual Scientific Assembly

Lectures, informal discussion conferences, and case presentations will be presented. This program is acceptable for 23 1/2 prescribed, and 8 1/2 elective hours by the A.M.A. Council on Medical Education. For information write: Interstate Postgraduate Medical Assoc. of N.A., P.O. Box 5445, Madison, Wisc. 53705.

New Orleans, Louisiana

November 21-21—American Society of Anesthesiologists

Workshop on Acid Base Balance

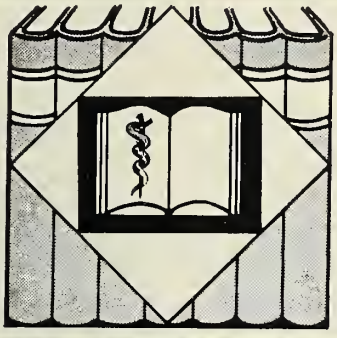
Fairmont Roosevelt Hotel-New Orleans, La.

November 28-December 1—American Medical Association-New Orleans

Clinical Meeting

For further information write: The American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, Illinois 60068.

(Save for reference)



the doctors library

Medical Pharmacology: Principles and Concepts. By Andres Goth, M.D. 5th Edition, St. Louis: C. V. Mosby, Publisher, 1970. 665 pages, $16.50.

The fifth edition of this classic textbook is comprehensive in its scope, but is still of a manageable length. The style makes this book a pleasure to read. Excellent drawings have been specially prepared and are freely used to explain the material. Much new information has been incorporated in this edition, and excellent references at the end of each chapter make it easy to pursue specific topics in greater depth. For these reasons this is the text that this reviewer recommends to medical students for their course in pharmacology.

Arthur J. Atkinson, Jr., M.D.

A Synopsis of Pharmacology. By V. C. Sutherland, Ph.D. 2nd Edition, Philadelphia: W. B. Saunders, 1970. 720 pages. $10.75.

This synopsis is intended "to meet the needs of all students of the health professions taking an introductory course in pharmacology" and as "a review to more advanced students and to clinicians." It is written in outline form and organized along traditional lines to cover 14 main classes of drugs. Specific consideration of the general principles of pharmacology is confined to the first 10 pages, and much that is conceptually new in pharmacology receives inadequate attention.

Arthur J. Atkinson, Jr., M.D.

the viewbox

(Continued from page 422)

DIAGNOSIS: *Primary Lymphedema.* Primary lymphedema has no demonstrable cause other than congenital abnormalities in existing lymphatic pathways.

In primary lymphedema there is an inherent structural abnormality in the lymph vessels of the extremity without evidence of pelvic or abdominal obstruction. An abnormal flow of contrast media may be demonstrated by filling of collateral vessels, extravasation into interstitial tissues, flow along perineural spaces, communications with veins, hypoplasia of lymph vessels, or delayed clearing of contrast media from lymphatic vessels after 24 to 48 hours.

Kinmouth divided congenital lymphatic abnormalities into four groups:

1. Hypoplasia, the most common type. In this condition there are unusually few lymphatics, which are larger than normal.
2. Dilated or varicose channels frequently associated with dermal backflow, wherein many small collateral channels fill in the skin.
3. Aplasia of lymphatics, considered to be a rather rare occurrence.
4. Dermal backflow, by itself seen rarely in the absence of varicose channels.

Even though lymphedema may be seen in only one extremity, these structural abnormalities appear bilaterally. In primary lymphedema the sex ratio is ten females to one male. There is no sex difference in secondary lymphedema, which more commonly produces unilateral edema and usually occurs in older persons.

The more severe the congenital defect in lymph channels demonstrated by lymphangiography, the earlier symptoms will appear. The patient may be free of swelling for years, even with marginally adequate lymphatics. However, as a result of recurrent skin infections or increased intra-abdominal pressure the lymph vessels may become obliterated. This leads to an incompetent system requiring collateral means of flow to return the lymph to venous circulation. The inadequate collateral system causes edema to develop because of poor drainage. Depending on the age of onset one may divide primary lymphedema into congenital, praecox, tarda and a senile form.

The lymphangiographic findings substantiate the diagnosis of primary lymphedema. Abnormal lymph flow occurs in the most distal portions of the extremity and is always bilateral. With increasing alterations of lymphatic flow lymphedema is seen more proximally in the thigh.

It differs from secondary lymphedema which is due to anatomic obstruction of the lymphatic channels by tumor, inflammation, radiation effects, surgery or trauma.

In secondary lymphedema the most striking finding appears just distal to the site of obstruction, with further abnormalities developing later in the distal part of the extremity. The anatomic obstruction to lymph flow may exist in the abdomen, pelvis, or extremity. If the obstruction is located in the pelvis we can expect to see a greater degree of abnormal flow in the thigh than in the calf, but if the obstructive element is near the calf, one cannot differentiate primary from secondary on the basis of the single limb lymphangiogram. Clinical information and the appearance of the other limb on lymphangiographic study is helpful in a differential diagnosis. Dermal staining of the skin with the preliminary skin dye can occur and is evidence of dermal collaterals even before the start of the Ethiodol injection.

Reference

Love, Leon, M.D. and Kim, Si Eon, M.D. "Clinical Aspects of Lymphangiography," Medical Clinics of North America. Vol. 51, No. 1, Jan., 1967

You can't blame the economy

The dramatic increase in welfare cases cannot be blamed on the economic slowdown, a Labor Department study shows. While welfare rolls historically rise and fall with the unemployment rate, this trend was reversed in 1963. Unemployment started dropping that year from a 5.7% rate while Aid to Families with Dependent Children cases began an uninterrupted climb, with a record 2.2 million families now on the AFDC welfare rolls.

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MANAGEMENT OF COMMON FRACTURES, One Week, October 25
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BASIC OBSTETRICS, One Week, November 8
SURG. & RADIATION THERAPY OF GYNE. MALIGNANCIES, Dec. 6
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GENERAL PRACTICE REVIEW, One Week, November 1
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Information concerning numerous other continuation courses available upon request.

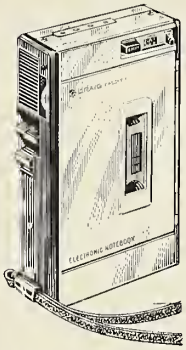
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Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 16 manuscript pages,** (including illustrations) and should be briefer if possible. Please enclose personal glossy photos of author or authors. Snapshots are not suitable for reproduction.

References should be numbered and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author (s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

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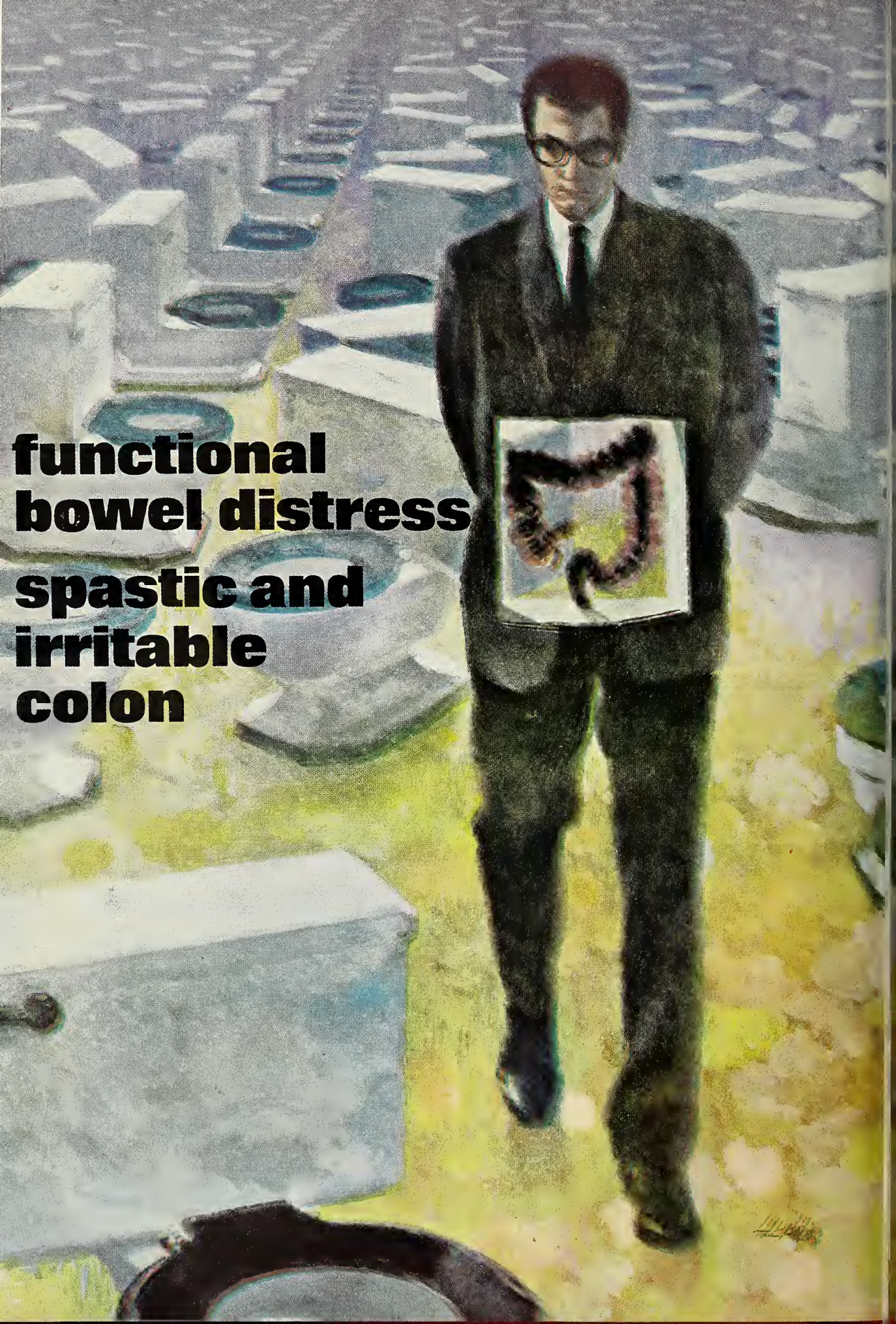
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REGISTERED AIA MEDIA DATA FORM


functional
bowel distress
spastic and
irritable
colon

In Illinois... and everywhere else...
a new alternative

NEW Trobicin® SPECTINOMYCIN DIHYDROCHLORIDE, PENTAHYDRATE, UPJOHN

single-dose treatment for intramuscular use only

a chemically distinct antibiotic indicated specifically for treatment of acute gonorrhea:
in the male–acute urethritis and proctitis
in the female–acute cervicitis and proctitis
when due to susceptible strains of *N. gonorrhoeae*

High cure rate:*96% of 571 males, 95% of 294 females
(Dosages, sites of infection, and criteria for diagnosis and cure are defined on page 3 of advertisement)

Assurance of a single-dose, physician-controlled treatment schedule

No allergic reactions occurred in patients with an alleged history of penicillin sensitivity when treated with Trobicin, although penicillin antibody studies were not performed

Active against most strains of Neisseria gonorrhoeae *in vitro*
(M.I.C. 7.5-20 mcg/ml)

A single two-gram injection produces peak serum concentrations averaging about 100 mcg/ml in one hour
(average serum concentrations of 15 mcg/ml present 8 hours after dosing)

NOTE: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the symptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any effective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for gonorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should be instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found hypersensitive to it.

For full prescribing information, including contraindications, warnings and precautions, please see last page of this advertisement.

*Data compiled from reports of 14 investigators.

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

Trobicin and the gonorrhea challeng

An accelerating epidemic— a decelerating susceptibility to penicillin

Gonorrhea is now the most prevalent reported communicable disease in the nation. The estimated number of new cases of gonorrhea in the United States exceeded two million for the first time in 1970. To compound the problems, strains of *N. gonorrhoeae* increasingly resistant to penicillin and other antibiotics are appearing throughout the country. Schedules of treatment which were effective only a few years ago now result in a significant percentage of treatment failure. *In vitro* studies have demonstrated that resistance of *N. gonorrhoeae* may also develop to Trobicin.

Thus, while aqueous Procaine Penicillin G remains the drug of choice for the majority of patients, the need for a non-penicillin, intramuscular antibiotic for acute gonorrhea in the male and female is abundantly clear. Such an antibiotic should be effective following a single intramuscular injection —and it should not demonstrate cross-resistance with penicillin

Trobicin—a new alternative specifically for the treatment of acute gonorrhea

Trobicin is indicated in the treatment of acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

High cure rates: 96% of 571 males, 95% of 294 females

No allergic reactions occurred in patients with a alleged history of penicillin hypersensitivity whe treated with Trobicin, although penicillin antibo studies were not performed.

Chemically distinct

Trobicin is structurally not related to any other antibio commonly used to treat gonorrhea.

The assurance of a single-dose, physician-controlled treatment schedule

Intramuscular injections should be made deep into the upp outer quadrant of the gluteal muscle.

Adult male: Single 2 gram dose I.M. in acute gonorrhe urethritis. Single 4 gram dose I.M. (should be divided betwee two gluteal injection sites) in gonorrheal proctitis and patients being re-treated after failure of previous antibiot therapy. In geographic areas where antibiotic resistance known to be prevalent, initial treatment with 4 grams intr muscularly is preferred.

Adult female: Single 4 gram dose I.M. (should be divided be tween two gluteal injection sites) in acute gonorrheal ce vicitis and proctitis.

Safety for use in pregnancy has not been established, nor ha safety for use in infants and children.

Clinical Results with Single-Dose Treatment, Intramuscularly* (Data compiled from reports of 14 investigators**)

	Dosage	Number of Patients	Number Cured	Percent Cured
Adult Males: Gonorrheal urethritis	**2 grams** **4 grams**	**475** **96**	**457** **93**	**96%** **97%**
Adult Females: Gonorrheal cervicitis	**4 grams**	**294**	**280**	**95%**

Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-Martin medium in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-treatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the follow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined that reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or failures. These cases were regarded as non-evaluatable and were not included in the table above.

The following reactions were observed during the single dose clinical trials: soreness at the injection site, urticari dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in norm human volunteers, the following were noted: a decrease hemoglobin, hematocrit and creatinine clearance; elevatio of alkaline phosphatase, BUN and SGPT. In single and mu tiple-dose studies in normal volunteers, a reduction in urin output was noted. Extensive renal function studies demo strated no consistent changes indicative of renal toxicity.

*4-grom doses were injected in two gluteol sites.

**Medicol Research Files, The Upjohn Company

a chemically distinct antibiotic indicated specifically for treatment of acute gonorrheal urethritis and proctitis in males and cervicitis and proctitis in females when due to susceptible strains of *N. gonorrhoeae*

new Trobicin®

STERILE SPECTINOMYCIN DIHYDROCHLORIDE PENTAHYDRATE, UPJOHN

single-dose treatment for intramuscular use only

terile Trobicin®
spectinomycin dihydrochloride penta-ydrate)—For Intramuscular injection:
gm vials containing 5 ml when reconsti-uted with diluent. 4 gm vials containing 0 ml when reconstituted with diluent.

n aminocyclitol antibiotic active *in vitro* gainst most strains of *Neisseria gonor-hoeae* (MIC 7.5 to 20 mcg/ml). Defini-ve *in vitro* studies have shown no cross esistance of *N. gonorrhoeae* between robicin and penicillin.

ndications: Acute gonorrheal urethri-s and proctitis in the male and acute onorrheal cervicitis and proctitis in the emale when due to susceptible strains f *N. gonorrhoeae*.

Contraindications: Contraindicated in atients previously found hypersensitive Trobicin. Not indicated for the treat-nent of syphilis.

Warnings: Antibiotics used to treat gon-rrhea may mask or delay the symp-oms of incubating syphilis. Patients hould be carefully examined and nonthly serological follow-up for at least months should be instituted if the diag-osis of syphilis is suspected.

afety for use in infants, children and regnant women has not been estab-shed.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae*.

Adverse reactions: The following reactions were observed during the single-dose clinical trials: soreness at the injection site, urticaria, dizziness, nausea, chills, fever and insomnia.

During multiple-dose subchronic tolerance studies in normal human volunteers, the following were noted: a decrease in hemoglobin, hematocrit and creatinine clearance; elevation of alkaline phosphatase, BUN and SGPT. In single and multiple-dose studies in normal volunteers, a reduction in urine output was noted. Extensive renal function studies demonstrated no consistent changes indicative of renal toxicity.

Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.

Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

Female— single 4 gram dose (10 ml) intramuscularly.

How supplied: *Vials, 2 and 4 grams —with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9%* w/v. Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.

Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae*.

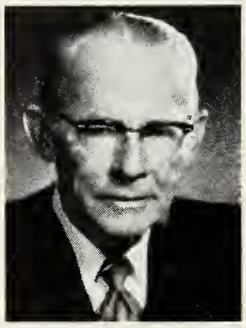
Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

For additional product information, see your Upjohn representative or consult the package insert.

MED-B-1-S (LWB

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001



the presidents page

Now we have the "ball!"

For years now, we've been complaining that physicians have no input into government health care programs—that we are unwilling partners in pie-in-the-sky programs designed by laymen.

Well, our Illinois Foundation for Medical Care has not only designed a new program to monitor hospital and nursing home stays under Medicaid, but on October 11 the state signed a contract allowing us to implement the program.

The new program is a golden opportunity for us. Through the Hospital Admission and Surveillance Program (HASP), we physicians will monitor the length of hospitalization and quality of care afforded Medicaid patients.

And I say "we physicians" advisedly. HASP Committees—composed of four physicians, two hospital administrators and a consumer will be set up at the local, regional and state levels.

Each hospital—or in some cases a group of smaller hospitals—will have a physician adviser and program coordinator appointed by the local HASP Committee. The physician will make all medical decisions. The coordinator, who may be a former military corpsman or a nurse, will handle day-to-day administrative work. Both will be paid for their services.

Length of stay criteria for various illnesses will be developed, again by we physicians, and longer stays will be permitted if medically necessary. Decisions of medical advisers can be appealed to local, regional or state HASP committees.

HASP will begin operation in Chicago hospitals with heavy Medicaid caseloads on Jan. 1, 1972. It will become fully operational in Illinois by June, 1972. The state estimates that if one day is cut from annual hospital stays of each patient, HASP will save $12 million in Medicaid funds during 1972. When fully operational for an entire one-year period, the savings are expected to be substantially more.

Long-range benefits of the HASP program are also significant. Through HASP, we will be able to aid utilization review committees. For the first time, utilization review information will be available on a statewide basis for the benefit of physicians as well as patients.

Because of the many questions physicians have on HASP, our state society has prepared film strips and other information which is available to the membership.

HASP is just one of the first of many new health care ideas our foundation hopes to develop. The foundation will keep physicians in control of health care delivery. If the voice of medicine is to be strong, so must the foundation be strong. I urge you to send in your membership application today. There are no dues.

We now have the ball—let's run with it!

L. T. Fuson M.D.

BLUE SHIELD REPORT FOR Illinois Physicians

Billing Blue Shield For Surgical Assistants, Consultations

When more than one physician provides services to a Blue Shield subscriber, each physician should complete a Physician's Service Report, list the services performed and indicate the fee for each service. He should also indicate that separate Service Reports will be submitted by other physicians. This not only aids our claims department in processing the claim promptly, but also, most importantly, helps to avoid the possibility of misunderstanding that may arise between the physician and his patient for billing for the services of another physician.

Because Blue Shield offers a large selection of basic contracts which may be modified to fit the needs or desires of a particular group by the addition of riders or endorsements, it is not possible to specify the covered and non-covered services and the extent of Blue Shield allowances. Physicians wishing this information may contact our office and provide our counselors with the patient's Blue Shield group and subscriber number.

Surgical Assistants

At present, all *Indemnity* Blue Shield certificates exclude benefits for the services of a surgical assistant.

Most of the basic Blue Shield *Usual* and *Customary* certificates exclude the services of surgical assistants. However, some groups have included this benefit rider (notably the U.S. Steel and Motors groups) and will pay for the services of technical surgical assistants if:

1. No interns or residents were available, or
2. The hospital had no intern or resident program, and
3. The procedure was one which required technical surgical assistance.

In such cases, the surgical assistant should submit a Physician's Service Report, reporting his services as a surgical assistant, the operative procedure performed, and the name of the operating surgeon. It is essential that each physician bill only for the services which he personally performed.

Concurrent Medical Care

When a patient is admitted to a hospital primarily for surgical or obstetrical care, additional benefits for concurrent medical care rendered by a physician other than the operating surgeon or obstetrician would be paid by Blue Shield "only in unusual instances where specialized medical care is essential to and distinct from the surgical and obstetrical care". Some examples of eligible claims are as follows:

A. The patient is admitted as a medical patient and treated medically for a period before being transferred to the surgical or obstetrical service. In such cases, the physician rendering the medical care should bill Blue Shield for his services to the date of transfer.

B. The patient is primarily a medical patient and the surgery performed is a minor procedure or diagnostic in nature. In these cases, the physician rendering medical care should bill Blue Shield for the entire period of hospitalization.

C. The patient develops a post-operative condition requiring specialized medical services. In these cases, the physician rendering medical care should bill Blue Shield from the date he enters the case to the date of completion of his hospital services.

D. The patient has a medical condition requiring close supervision both pre- and post-operatively. In this case, the physician should bill Blue Shield for the entire period of hospitalization and describe in detail the condition of the patient.

In all examples above, each physician should submit a Blue Shield Service Report form for the services he personally provided.

Consultations

No Blue Shield *Indemnity* certificates provide benefits for consultations, and only a few *Usual* and *Customary* certificates provide such benefits. The amount of payment is based on the *Usual* and *Customary* certificate in force.

As the factors which contribute to the eligibility of claims for medical care to our subscribers vary with each type of contract in force, it is extremely important that billing procedures be followed completely and accurately. Each physician should bill only for those services which he himself performed, list his services in detail, state his fee for each service, and provide any additional information which would aid us in processing his claim. In this way, he can help us to provide better service to our subscribers and to the medical community.

Extracted from an article written by Blue Shield for Chicago Medicine, *Vol. 74, No. 13, June 19, 1971. Physicians wishing a reprint of the article may contact Joanne Rake, Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 222 North Dearborn Street, Chicago, Illinois 60601.*

(This is not an advertisement)

ASK BLUE SHIELD
• • • ABOUT MEDICARE

UNITED MEDICAL LABORATORIES RECEIVES RECERTIFICATION

Notification was recently sent to Illinois physicians that the Social Security Administration no longer considered the United Medical Laboratories, Inc. certified to perform cytological examinations. United Medical Laboratories, Inc. has acted to correct the deficiencies and has been recertified by the SSA to perform these examinations. Recertification became effective September 8, 1971.

The cytology laboratory's provider number is 38-8024, and it is located at 10716 N. E. Sandy Boulevard, Portland, Oregon 97220.

TIME LIMITATIONS FOR FILING CLAIMS

The Social Security Admendments of 1967 established a time limit within which a claim for services under Part B Medicare must be filed. Claims for services performed in the first nine months of a calendar year must be submitted before the end of the following calendar year. The time limit for services performed in the last three months of a calendar year will be the same as if the services were furnished during the subsequent year.

December 31, 1971 is the last day for filing claims for services performed October 1, 1969 through September 30, 1970. For purposes of the time limit, a claim is any written notice submitted by or on behalf of a claimant which indicates a desire to claim payment from the Medicare program, i.e., an incomplete SSA 1490, a physician's bill, or a note questioning benefits for specific services could constitute a claim.

Since the cutoff date for services furnished in the first nine months of 1970 is drawing near, we recommend that claims for this period be submitted to the Medicare office as soon as possible.

SSA Changes In Lab Certification

The following laboratories have been certified for Medicare participation by the Social Security Administration:

Norwest Medical Laboratory, 2336 West Chicago Avenue, Chicago, Illinois 60622.

Zeitland X-Ray and Clinical Laboratory, 2800 Milwaukee Avenue, Chicago, Illinois 60618.

The following laboratory will no longer be certified for Medicare participation as of December 31, 1971:

Gerson Clinical Laboratory, 1 North Pulaski Avenue, Chicago, Illinois 60624.

The following laboratories have received approval to perform EKG services in addition to the procedures for which they were previously certified:

Springfield Clinic, 1025 South Seventh Avenue, Springfield, Illinois 62703.

Post Graduate Hospital Laboratory, 2400 South Dearborn Street, Chicago, Illinois 60616.

Norwest Medical Laboratory, 2336 West Chicago Avenue, Chicago, Illinois 60622.

Humbolt Clinical Laboratory, 2018 South Ashland Avenue, Chicago, Illinois 60608.

Dental Benefits Available Under Part B Medicare

No benefits are available under Part B Medicare for items or services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth. Structures directly supporting the teeth means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of teeth, and alveolar process.

However, benefits are available for services performed by a doctor of medicine (M.D.), doctor of dental surgery (D.D.S.), or doctor of dental medicine (D.D.M.) for surgery related to the jaw or any structure contiguous to the jaw or for the reduction of a fracture of the jaw or facial bones. Dental splints and other appliances used in the reduction of a fracture of the jaw or facial bones are also included in the benefits.

If an otherwise uncovered procedure or service is performed by a physician or dentist as incident to and as an integral part of a covered procedure *performed by him*, the total service performed on such an occasion is covered. For example, the reconstruction of a ridge performed primarily to prepare the mouth for dentures is a noncovered procedure. However, where the reconstruction of a ridge is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes), the totality of the surgical procedures would be a covered service.

Extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease is also covered even though the actual radiation treatments are not performed by the physician or dentist who pulls the teeth.

When an excluded service is the primary procedure performed, it is not covered regardless of the complexity, difficulty, or number of covered procedures performed in connection with it. For example, the extraction of an impacted tooth is not covered, nor is an alveoplasty or a frenectomy when either of these procedures are performed in connection with an excluded service such as preparation of the mouth for dentures.

Coverage of such services as the administration of anesthesia, diagnostic x-rays and other related procedures depends on whether the primary procedure performed is covered. Thus, x-rays taken in connection with the reduction of a fracture of the jaw would be covered while those taken in connection with the care and treatment of teeth would not.

Payment can be made for a covered dental procedure no matter where the service is performed. Therefore, the hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.

(This is not an advertisement)


DARVON®
COMPOUND-65
65 mg. propoxyphene hydrochloride, 227 mg.
aspirin, 162 mg. phenacetin, and 32.4 mg. caffein
Lilly
Additional information available to the profession on request.
Eli Lilly and Company • Indianapolis, Indiana 46206
101488

Twenty-four clinics For crippled children

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The Division will hold 17 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social, and nursing services. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

December—

1 Rock Island Cerebral Palsy—3808 Eighth Avenue
1 Carmi—Carmi Township Hospital
1 Hinsdale—Hinsdale Sanitarium
2 Sterling—Community General Hospital
2 Springfield—St. John's Hospital
2 Effingham—St. Anthony Memorial Hospital
2 Lake County Cardiac—Victory Memorial Hospital
3 Chicago Heights Cardiac—St. James Hospital
7 Belleville—St. Elizabeth's Hospital
8 Champaign-Urbana—McKinley Hospital
9 Litchfield—Madison Park School
14 East St. Louis—Christian Welfare Hospital
14 Peoria—St. Francis Children's Hospital
15 Springfield Pediatric Neurological—Diocesan Center
15 Chicago Heights General—St. James Hospital
16 Bloomington—Mennonite Hospital
16 Rockford—Rockford Memorial Hospital
16 Elmhurst Cardiac—Memorial Hospital of DuPage County
17 Chicago Heights Cardiac—St. James Hospital
17 Evanston—St. Francis Hospital
21 Rock Island Area General—Moline Public Hospital
22 Aurora—Copley Memorial Hospital
27 Peoria Cardiac—St. Francis Children's Hospital
28 Peoria—St. Francis Children's Hospital

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.

IMJ
Illinois Medical Journal

By Thomas T. Tourlentes, M.D.
Chairman, ISMS Committee on Aging
Editor, Special Issue on Geriatrics

Population age 65+: Special issue on geriatrics

"Grow old along with me! The best is yet to be." —Robert Browning

IT WAS BROWNING who also described old age as "the end of life for which the first was made." However, for millions of Americans old age is not as the famous poet described it.

With advancing years, they struggle, often alone, against a multitude of health, housing, transportation, employment and retirement problems. It's ironic that upon retirement—after a lifetime of contributing to this nation's prosperity—many oldsters are suddenly barred from sharing this prosperity. Even if a man retires with an income adequate for his needs, ten years later he may find inflation has caused him to no longer have enough money to live in comfort.

Today, one out of ten Illinoisans has reached or passed his 65th birthday. Our nation's 200 million population contains 20 million elderly. One out of every ten receives social security benefits, but the average check amounts to only $117. Is it any wonder that an estimated five million older people live in households with incomes below the poverty level? Some two million have been forced to turn to welfare assistance.



THOMAS T. TOURLENTES, M.D., former long-time superintendent of the Galesburg State Research Hospital, and regional director of the Peoria Zone of the Illinois Department of Mental Health, is now director of psychiatric services for the Fransiscan Hospital complex near Rock Island. Dr. Tourlentes received his M.D. degree from the University of Chicago and is a Diplomate of the American Board of Psychiatry and Neurology. He is also a certified mental hospital administrator, a Fellow of the American College of Psychiatrists, and a Fellow of the American Psychiatric Association.

Population age 65 +

Nearly all older Americans feel this squeeze on their fixed incomes. A lack of funds often keeps the elderly from receiving adequate nutritional and preventive medical care. Also, many elderly people do not take as good care of their health as they might, because they believe they cannot live much longer anyway.

Statistics, however, show this belief is not justified. The average 65-year-old person can look forward to 10 more years of life. Out of every 1,000 people aged 65 to 75, only about 38 will die during the year. Increasing numbers of persons are reaching the century mark. Some 3,574 persons receiving social security benefits today are 100 years old or older.

Trends show the elderly population is getting older. More than seven million of our 20 million elderly are 75 or older. It is estimated that there will be nine million persons over 75 years old in 1980. With more older people and "older" old people, the increase in the need for medical care for this group will be increased.

So it is right, and even timely, that we focus our attention in this issue on the elderly—especially since national interest in these problems will be awakened by the White House Conference on Aging in Washington, D.C., November 28 to December 3.

President Nixon charged the Conference with developing a "more adequate national policy for older Americans." We hope the Conference succeeds. Members of the ISMS Committee on Aging and many other members of our State Medical Society participated on the community and local levels in drafting preliminary recommendations which were discussed during the Conference.

Our State Medical Society and its Auxiliary was ably represented in the Illinois delegation to the White House Conference by Dr. Edward Cannady, a past president, and Mrs. Willard C. Scrivner, wife of our current Chairman of the Board. Mrs. Scrivner also is first vice-president of the AMA Woman's Auxiliary. We hope that the "powers-that-be" in Washington listened to their advice, and did not use the Conference simply to promote their own special interests and pet projects.

The following papers deal with current and practical approaches to the management of the growing number of geriatric patients who daily seek our professional help and guidance. The Committee on Aging of the Illinois State Medical Society is grateful to the panel of distinguished authors who took time from their busy lives to prepare these timely, provocative, and useful contributions to the literature of an important but largely neglected professional field.

There is no immunity from old age. We must all face it. The quality of our own "golden years" may very well be determined by what we are willing to do today for our elderly friends, neighbors, and relatives. Can we afford to do less than our best? ◄

End of an era

Modern civilization has reached the stage where, henceforth, no new use of technology, no increased demands on the environment for food, for other natural resources, for areas to be used for recreation, or for places to store the debris of civilization, can be undertaken to benefit some groups of individuals without a high risk of injury to others. No environmental involvement of man can any longer be regarded as all good or all bad. Problems can be mitigated, but absolute solutions are probably unattainable. The best that can be sought, therefore, is to optimize, to try to achieve the wisest cost-benefit decision for society for each action contemplated. Such a strategy requires a strong base of scientific knowledge and understanding of the environment, ability to predict reliably its future course, and, especially, the ability to construct models through systems analysis of the environment and of man's interaction with it on a scale never previously achieved. (Environmental Science. Challenge for the Seventies. **National Science Board 1971**, p. 7.)

By Marshall A. Falk, M.D./Wilmette

Psycho-Social aspects of aging

There are presently about 20 million people in this country 65 years of age or older.

WHOEVER TALKED ABOUT "growing old gracefully," or "the golden age of the elderly," must have expired rather suddenly prior to the age of 50, in a chauffer-driven limousine on the way to his mistress' penthouse after receiving an alumni-of-the-year award from his college graduating class. In light of our present-day knowledge, aging is not only something that is *not* graceful or golden but rather can be charitably considered by many as a curse of living.

The 65+ population in society

There are presently about 20 million people in this country 65 years of age or older. In 1985, this number will be close to 25 million and by the year 2000 the number should reach 30 million. This group represents a very large unorganized, presently impotent, minority group which has been uniformly discriminated against by business, government, families and close friends. The discrimination against this geriatric group knows no racial, ethnic, social or economic boundaries. It's analogous to putting an old horse out to pasture but no one knows where, or even if, the pasture exists and there is no rush to indicate that anyone is concerned over the problem. This is peculiar because at some time we all hope to have a vested interest in this problem. This is a comment on our ability to deny an emotionally charged problem as well as the youth oriented society which we live in.

Most people 65 years of age and older live in the central part of the city; people under the age of 65 primarily live in the suburbs. Whereas half of the population from 25 to 64 years of age has had at least a high school education, half of the 65+ has not completed elementary school. Almost 16% of the 65+ are functionally illiterate. This is four times the illiterate proportion of the 25 to 64 group. Low income and lack of assets are characteristics of "the golden age."

Financially, the prospects after age 65 are even more dismal. Half of the 7.1 families with 65+ heads had incomes in 1968 of less than $4,590, which is less than half of that for younger families. Half of the elderly people living alone had incomes of less than $2,000. In 1968, a quarter of all older persons were living in families where the income is below the poverty level.

Against this background of social disparities and discrimination one has to consider the cur-



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rent "revolution" that is going on in this country. The physical violence, anti-government slogans, burning of flags and the accent on youth are not conducive to enhancing the security of our elderly. The whole concept of a revolutionary movement would be contrary to the usual rigidity which characterizes aging. At the same time, any radical change or ongoing changes similar to what is currently prevalent in this country would not increase the security of an already demeaned and insecure group. From the view of the nation's youth, the elderly would appear to be a fringe group of an already excluded segment of society. The gap between our youth and geriatric segments would appear to be so wide that it is beyond the realm of comprehension and therefore would not often be discussed. The gap between these groups would seem to be more of a concern for the aged than the youth. In effect, the changes caused by youth in our society are a vivid reminder of their elders impotence and hopelessness regarding a future. It should however not be taken out of perspective, i.e., it is, in fact, just one of the many problems facing the aged individual. In retrospect, the elderly look back and remember the excitement and fear of youth, along with the responsibility of middle age. In their present situation however, very few find their memories enough to sustain them, nor their anticipation enough to encourage them.

Many large companies and unions are considering, among other inflationary measures, the four-day work week and an earlier retirement age. Both of these measures ought to have a deleterious effect on the already accelerated social aging process. *The ageds main life line is the ability to be useful and to maintain at least a facade of productivity.* Any direction causing an earlier displacement from that position would lead to a further reduction in self-esteem. It would almost seem that the needs of our elderly population are contrary to the needs of our society as a whole.

The process of inflation and the unsteady stock market have proven disastrous to many individuals over 65, who had a fixed if not meager income. It is no small wonder, considering all these social pressures, that the suicide rate of the 65+ age groups is higher than most subgroups of our society except the young adult.

Mind and body of the aged

With all this going on, the physician has not exactly been a shining light in a sea of darkness. As a group, the medical profession has distinguished itself by a clear lack of interest, avoidance, feeling of hopelessness and, at times, contempt for the "golden ager." The evidence for this is obvious in the physician's approach to what he calls "Krocks," his frequent but often incorrect diagnosis of senility, his lack of attendance to patients transferred to nursing homes, and the often total neglect of the subject in medical schools. The reasons for the medical profession's attitudes are varied and complicated, but it is interesting to note that physicians as a group also have a high suicide rate.

The almost universal phenomenon associated with aging is a loss of self-esteem. This would be a normal consequence of biological slowdown and social intimidation. The social intimidation can be from society as a whole and its emphasis on production, or rejection by the smaller society known as the patient's family. The family and most noticeably the children relate to the aging patient in a role reversal. The parent, who for years was relied on and looked to for advice, now finds himself relying on his children for financial and living help. At the same time, he is relegated to taking advice given by his children, regardless of his own convictions or their competence. It's a strange phenomenon that, once an individual has turned 65, he is often treated as though he has lost his wisdom, experience and judgment. The elderly patient finds himself relegated to the extra bedroom, the nursing home or worse yet, total abandonment. It is an abrupt role change for the aging patient that causes a loss of self-esteem and a resulting depression of various symptoms and degree. The occasional loss of memory, loss of friends, baldness, dentures, decrease in hearing, decrease in visual acuity and general changes in self-image also contribute to the loss of self-esteem and resulting depression. The female loses her looks and role, the male loses his social potency. In our society, depression and sometimes agitation are so conspicuous and common that they are often considered normal attributes of an aging population.

Many times elderly patients present with somatic symptoms (chest, abdominal, head or back pain) as a sign of depression. They often don't cry or have obvious depressive thoughts. This concept is extremely important because an elderly patient with somatic symptoms should have a detailed history done, lest he become a suicidal

statistic by his own hand or be part of the death statistics of a hospital because of the inocuous tests done to rule out any and all organic diseases.

Paranoid delusions are also extremely common symptoms in aging patients. The delusion is often related to someone taking something from them, usually money or clothes. Another common paranoid delusion is related to sexuality. This is more common in women and it is often related to a delusion that they are the object of an imminent sexual attack. Both the sexual delusion and the one related to a loss deal with themes which played a significant role in the patient's life. It is as if the geriatric patient is saying, "It is not I that have lost my money or my station in life, someone has stolen it," or "I am still sexually attractive to men." Both of these delusions are face-saving devices, but are quite troublesome to the family and patient. They are often refractory to various therapies and require hospitalization.

The geriatric patient is usually very rigid in the sense that he is resistant to change and may become extremely agitated or depressed with changes in living quarters, deaths, etc. This is particularly true of patients who were perfectionists or compulsive earlier in their lives. Geriatric patients lack resilience—it's almost as if they had emphysema of their psyche. Therefore, the less changes made in an elderly patient's life, the better. Changes from home to nursing home to hospital to another home could be disastrous, and could contribute to the death of a patient. They often have difficulty in mastering their environment. Multiple changes can often lead to an acute agitated state with obsessional thoughts and paranoid ideation. These severe psychiatric symptoms may be avoided with family support and compassion toward the elderly.

Future outlook

The psycho-social problems of aging at the present time have a poor prognosis. The elderly are not able to lobby or exert pressure as a group, so their social plight will not change in the immediate future. The often cursory planned geriatric centers and social clubs do little to raise a person's self-esteem. Often these hastily planned centers are more degrading in the sense that weaving baskets as a forced activity can be degrading to a retired executive. The losses of the aging person, real or imaginary, biological or social, continue to take their emotional toll.

The remedy for the psycho-social problems of aging will not be found in medication, and it will be a long time before we have another social revolution—we haven't finished this one as yet. So, if you are planning to live past the age of 65, perhaps you should give it some thought. It might be well to remember that aging is not a condition, a disease, or a plague, but rather a process—a process that involves all of us. The changes are subtle but the symptoms or effects can occur suddenly. The process of aging is universal and simultaneously individual. The society has an impact on the individual geriatric patient as well as a collective effect. This should not preclude an observation that it is a two-way street—the geriatric individual has an effect on the society as well. The greater the number of elderly people in our society the greater the impact on our social and economic structure.

The medical profession, certainly not by choice, is a potentially primary influence on the psycho-social problems of aging. So far, it would appear that any effect we have had has been by default. Physicians, as a group, probably would deal more directly and influentially with aging people than any other organized group. Perhaps it's time that we take some cognizance of the process. We have certainly dealt effectively with more complicated problems but perhaps none so frightening. ◄

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Taxes outpace rising income

The increased income average American families can expect by 1980 will be devoured by an even faster growth in the rate of taxes, the Chamber of Commerce of the United States reports. Family income will rise 60% during the 1970s, but the same family can expect their federal, state and local taxes to increase 100%.

By Jack Stevens, M.D.

Management of orthopedic problems in the aged

Orthopedic problems tend to be less fascinating to the orthopedist in proportion to the disability they cause the patient.

THE ORTHOPEDIC PROBLEMS of the elderly are numerous and varied. Unfortunately, they often call forth little interest from the orthopedist because they tend to be less fascinating to him in proportion to the disability they cause the patient. Almost total disappearance of the diseases that occupied much of their attention some years ago—poliomyelitis, skeletal infections —has, however, led many orthopedic surgeons to look at other fields of interest. Simultaneously, they appear to be accepting the fact that orthopedics is a specialty in which surgery is not necessarily the *sine qua non,* and inter-specialist cooperation is becoming very much the order of the day. I take specialists to include not only doctors but nurses, physical and occupational therapists, social workers, brace-makers and many other so called paramedical personnel.

Let us look at the well worn and time honored diagnostic classification of disease:

Congenital; Developmental; Traumatic; Inflammatory; Neoplastic; Degenerative; and Metabolic. Skeletal disorders in the older subject encompass the last five of these seven varieties, often with interesting modifications when compared with similar disorders in younger persons.

Trauma

Three modifying characteristics of musculoskeletal trauma in the elderly merit consideration. These are: daily activities; osteoporosis; and metastatic tumors.

Clearly, the older members of our society are but little exposed to the hazards of modern-day, high-speed living. Their injuries, then, are for the most part less complex than those encountered in the working population. On the other hand, atrophy has already made inroads into the human frame and this affects the skeleton as osteoporosis. It is known to be commoner in elderly people who sustain fractures than in those who do not, its diagnosis is difficult and depends on different criteria in different centers and its treatment remains empirical and largely ineffective.

Fractures

The management of common fractures in the geriatric patient is worthy of review.

Colles' fracture of the distal 2 centimeters of the radius is usually associated with a fracture of the ulnar styloid. Displacement classically includes shortening, the distal fragment being rotated and angulated dorso-radially. Adequate reduction can usually be achieved using local or regional anesthesia, and immoblization is for six weeks in a short or long arm cast. Physical therapy is desirable not only after the cast is removed but also during the period of immobilization if shoulder and finger stiffness are to be regularly avoided. A check X-ray one week after injury is desirable in most instances since comminution of the dorsal cortex predisposes to ready re-displacement even in the cast. Complica-

tions such as median nerve injury and late extensor tendon rupture are rare, but mild to moderate residual dysfunction at the wrist is not at all uncommon. I believe that intensive exercise throughout the treatment period will ameliorate this.

Almost confined to our older patients is the fracture of the neck of the humerus. This is usually impacted and may show angulation into abduction or adduction. Here, the need is for ultimate mobility, and to this end, immobilization in a sling and swath is curtailed. As soon as motion is possible without pain, usually after about ten days, gravity-assisted pendulum exercises are started and the advance in range of motion under increasing muscle control is fairly rapid. Again, complications of any note are very uncommon.

Osteoporosis, as is well known, predisposes not only to these fractures but also to end-plate collapse and wedge fractures of the vertebral bodies. These are, of course, entirely stable and most unlikely to be accompanied by neurological symptoms. The lumbar and dorsal regions are most frequently affected. Treatment is entirely along symptomatic lines. My experience has been that these patients find the wearing of any suitable brace intolerable, and I do not now recommend this. Simple analgesics and muscle relaxants are appropriate.

Fractures of the proximal femur constitute an increasing part of the orthopedic surgeon's practice and when it is realized that the average age of the patients affected is 74 years, there can be no question about the geriatric nature of the problem. Two types are recognized; the trochanteric and the intracapsular. The first of these is usually treated with a nail plate in the anticipation that the cancellous bone of the area, with its good blood supply will heal well in about three months. There is a tendency to have these patients walking earlier and I believe this is reasonable where accurate reduction of the medial cortex and excellent fixation have been achieved in a noncomminuted fracture. It should not be forgotten that good results have been reported from simple traction although this treatment method has the serious disadvantage of keeping the patients in bed. Recent refinements in operative treatment include the development of very strong one-piece nail-plates and medial displacement of the shaft. The first is established the second is still on trial.

Fracture of the femoral neck within the hip joint capsule is still justifiably regarded as the "unsolved fracture." Manipulative reduction with internal fixation is desirable under the age of 65, beyond which limit prosthetic replacement is appropriate. But the physiological age of the patient must be considered, too. If it is decided not to decapitate the femur, success in management will depend upon the accuracy of the reduction and the rigidity of the fixation. It is now common practice to use a telescoping nail plate and most of us regard the simple tri-flanged nail or the multiple threaded pin technique as being obsolete. There is also good evidence now that successfully treated patients can safely be ambulated with weightbearing two weeks after operation and I believe we should do this more often. The recognized complications of non-union and avascular necrosis seem not to depend upon early weightbearing and when they occur may call for secondary prosthetic replacement. Primary prosthetic replacement is not without its hazards. It carries a higher mortality rate for obscure reasons and morbidity is not uncommon from wound infection, dislocation and loosening of the prosthesis.

It is a sobering fact that the overall mortality rate in patients with fracture of the proximal femur is 20% during the first 12 months after injury.

Pulmonary embolism and cancer

Sevitt has stated that the commonest cause of death in the elderly injured patient is pulmonary embolism from pre-existing venous thrombosis. This whole entity is the subject of intense clinical research and prophylactic anticoagulation is widely practiced. Since our clinical diagnosis is so fallible and reliable tests have yet to be developed, this regime has some merit. It also has dangerous complications and perhaps its failure to become widely accepted indicates a proper measure of caution among orthopedists. Emphasis is shifting to better diagnostic tests and at least one of these, not much more complicated than taking the blood pressure, has great promise.

Pathological fractures represent a real challenge. In an age where cancer itself is being

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treated more and more aggressively, it behooves us to adopt a more aggressive approach to these fractures. We cannot tell how long the patient will survive after the cancer has been diagnosed or after the diseased bone has given way. Therefore, I believe we should fix these fractures in the best possible way.

Prophylactic fixation of a bone bearing a metastasis is prudent where it is practicable if the area of disease is extending. This re-inforcement may last for the rest of the patient's days and is a better approach than waiting to treat the fracture when it occurs. The presently available intramedullary rods are among the most useful devices in this field and if they do not permit normal function in lower limb pathological fractures, at least they will give sufficient immobilization to relieve pain and to avoid the persistence of a flail limb. One aspect of some concern with pathological fractures is whether and when palliative radiotherapy should be used. If the primary tumor has been identified as one that is radiosensitive, then radiotherapy is desirable. The question as to whether this should be given before or after surgery is hotly debated in some circles. I believe that the disadvantages of irradiating a limb which already contains metal are outweighted by the better chance for post-operative healing of non-irradiated tissues. The possibility of intra-operative dissemination of tumor cells is perhaps academic under the circumstances. In either case, it is unlikely that the healing process, which undoubtedly occurs in pathological fractures, will be significantly affected. Many of these fractures do indeed heal.

One of the areas of future development comprises bone reinforcement with cement. Methyl methacrylate has been developed as a cement to anchor prosthetic devices in bone. It seems to me that there is considerable potential for the use of this material in pathological fractures. One such technique which I have used with gratifying results has involved the removal of the upper end of a femur dissolved by metastasis and the replacement of this with a long stem Austin Moore prosthesis. This can be anchored in the distal femoral shaft only if cement is used. There is, of course, some residual weakness of motor power about the hip but ambulation has been possible, and one patient even declined the use of crutches or canes to help with this.

Arthritis

Dr. Schmid has dealt with degenerative joint disease in the elderly. The orthopedic surgeon is occassionally involved in the treatment of this disorder and rheumatoid arthritis when the disability it causes is significant. Pain relief is the primary aim but restoration or retention of function is desirable. Until recently there was but a rather inadequate repertoire of surgical procedures available and each had its drawbacks. In brief, we have: soft tissue operations; osteotomy; arthrodesis and arthroplasty. Each has its particular indications and limitations. The number and location of the involved joints has a distinct influence or recommendation for surgery and, in any event, a painless mobile joint which is stable is the goal. The recent development of total hip replacement has dramatically changed the outlook for many older people. This procedure has its own particular problems but experience with and development of such an operation may prove to be enormously beneficial to a number of our senior citizens. There is little doubt that similar procedures will be developed for other joints, of which the knee is probably the most important. My own experience of total hip replacement has been limited because I have chosen to be quite selective in its use. My initial impression is one of very great enthusiasm. Without wishing to encroach upon the preserves of Dr. Schmid and his colleagues in arthritis, it is clear to me that in this branch of medicine there is, par excellence, a need for collaboration between rheumatologists and orthopedists. We have a combined clinic for this purpose and the patients and doctors all derive considerable benefit from its existence.

A more mundane manifestation of joint degeneration in the elderly is the so-called cervical spondylosis. As with any spinal disorder, pain is of three types: local spinal; referred somatic and nerve root irritation. Each of these merits recognition. The patient with a stiff neck, occipital headache, upper limb dysesthesia and consequent disturbed sleep is well known to us all. He or she may have little to show in the way of physical signs apart from limited neck motion and a positive foramen compression test. Symptomatic treatment is generally advisable and local spine fusion is rarely needed. I believe that if these patients are given analgesics and muscle relaxants, and instructions to wear a soft, wrap-around collar in the house and at night (perhaps at work, also) for between six and 12 weeks, improvement can be anticipated in 95% of cases. Failing this simple program, traction and other medication

like indomethacin and butazolidin are worth trying. Since the elderly patient's cervical spine tends towards a flexion deformity, it is thoughtless to recommend the sort of plastic collar which forces the neck into hyper-extension. For the same reason, traction if used, should be applied in a posture of neck flexion to be best effective.

The elderly rheumatoid arthritic presents a problem in total and local management. So extensive is the range of orthopedic assistance available that to catalog them here would occupy too much time. Suffice it to say that this is a disorder in which the patients may derive especial benefit from cooperation between rheumatologist and orthopedist. They must also rely on help from physical therapists and other ancillary services.

There is sufficient evidence now to demonstrate the deleterious effects of the empirical use of corticosteroids given systemically or as intra-articular injections that this form of treatment should be abandoned except in very special circumstances.

Vascular Disorders

These are particularly frequent in the elderly and the orthopedist may find himself involved in two important aspects of them.

Ischemic gangrene of the lower limbs, whether of arteriosclerotic or diabetic nature, is a clinical problem of significant magnitude. Treatment is aimed at controlling any infection, providing the best possible circulatory state by grafting or sympathectomy and performing amputation at the most appropriate level. The re-introduction of some aspects of amputation surgery has changed our practice a little.

There is a tendency to suture divided muscles to the bone with the aim to give better motor control of the stump, improve local circulation and decrease the period needed for stump shaping by regular bandaging.

The application to an amputation stump of a well molded cast using elastic plaster bandages is an advantage in itself. It may be supplemented on the operating table or some days later by the fitting of a pylon for early weight bearing.

The elderly patient would benefit from an end-bearing stump with a simple prosthesis. I believe that we should pay more attention to Syme's amputation, even done in stages, and to through-the-knee amputation. A simple pylon may better serve the elderly patient with an end-bearing knee disarticulation stump than would a sophisticated, above-the-knee prosthesis.

A very different series of vascular disorders in which exciting new developments are being introduced are those which occur intra-cerebrally as "strokes." It has been well demonstrated that intensive therapy will enhance body image, prevent and correct deformities caused by spastic muscle imbalance, improve control of movements and lead to purposeful use of limbs to permit greater independence. This is the base upon which improvement may be added through the use of lightweight functional braces, intraneural injections of phenol and a limited number of quite specific operations to weaken or transfer spastic muscles and to release joint contractures. This is a whole new field and one in which a team approach is essential for evaluation, for the description of objectives and for the prescription and provision of treatment to reach those objectives. The patient population concerned is quite large and there is a great need to reduce the disability in each member to the extent to which this is possible. We shall undoubtedly see a great change in outlook of both patient and doctor as these new developments become established practice.

Summary

The range of musculo-skeletal disorders encountered in the geriatric patient is remarkably extensive. Happily, increasing involvement of orthopedic surgeons is producing new ideas about how they might be handled. The importance of interspecialty cooperation in the rehabilitation of the geriatric patient cannot be over-emphasized. Without this, the purely surgical efforts of the orthopedist are likely to be much less effective and, indeed, they should never be undertaken. ◄

Interdependence of business and education

"Today the relation of business and education can be summed up in one word: Interdependence. Certainly business as we know it today could not exist without the trained minds of scientists and engineers in all fields, including now even the science of business itself." —F. Ritter Shumway, president, Chamber of Commerce of the United States.

By Don B. Cohen, M.D., Michael W. Witwer, M.D., and Frank R. Schmid, M.D.

Arthritis in the aged

The occurrence of definite arthritis and rheumatism among the aged in the U.S. is 28.6%.

ADVANCING AGE IS commonly associated in the minds of physicians and patients with arthritis. Yet, despite the ready acceptance of such an association, precise efforts directed toward diagnosis and well-planned therapeutic programs are all too often lacking in the care of older people. In part, this may represent a defeatist attitude toward the geriatric patient and, in part, lack of knowledge. Recent clinical and experimental studies, however, have provided new insights into the rheumatic problems found in old age. These are highlighted in this report under the following headings:

1. Rheumatic diseases unusual in older people.
2. Rheumatic diseases found in all age groups but presenting complicating features when occurring in the aged.
3. Rheumatic diseases which cluster in the older age group.
4. Special aspects in the management of rheumatic diseases in older people.

A large percentage of people in the United States are both aged and arthritic. A definition of old age cannot be made strictly on chronological lines, as the vitality of the individual varies, but, in general, for purposes of this discussion, a dividing line of 65 and above has been chosen. The occurrence of definite arthritis and rheumatism in the United States is about 6.4%, but among the aged, this rate rises to 28.6%.[1] The majority of all persons living beyond middle age have some rheumatic complaints.[2]

An older person, just as a younger person, is exposed to some variety of agents which can cause arthritis--infection, trauma, metabolic derangements, hypersensitivity reactions, etc. The increased incidence of arthritis in this older group may be related to progressive biochemical and structural changes which have taken place in the tissues and skeletal system over a period of years. Biochemical studies done on older people, for example, show that intermolecular crosslinking is more extensive in their collagen, and the collagen is more insoluble than in younger people.[3] There are also changes in the mucopolysaccharides that make-up the ground substance in the aged. Though mucopolysaccharides are probably in active flux throughout life, the particular kinds of mucopolysaccharides found in older age groups differ from those found in younger people.[4,5] Immunological changes also occur in the aged, which may affect the presentation and/or the course of the rheumatic disease. To what extent these various changes complicate the clinical expression of disease is gradually being determined. Even with incomplete basic knowledge, however, it is clear that in approaching the undiagnosed elderly patient, one now has a large body of clinical information available.

1. Rheumatic diseases not commonly seen in the aged.

Certain genetic conditions tend to become less influential in older people. The youngster

with agammaglobulinemia who develops rheumatoid arthritis is not likely to achieve an old age.[6] With the use of antibiotics, however, some patients with agammaglobulinemia survive, and many of them later develop arthritis.

Gout occurs in old age, but most often is a disease that has been present since the individual was 30 or 40.[7] The onset of gout rarely occurs in people over 65, unless it is precipitated by the hyperuricemia of polycythemia vera, myeloid metaplasia or leukemia.[8]

Acute rheumatic fever tends to be less common in the elderly.[9] Whether this is a true decline in rheumatic fever, or whether our ability to make a diagnosis is hindered by a change in the clinical expression of the disease (polyarthritis alone without other manifestations) is not clear, although the former possibility seems more likely. In addition, the elderly are less likely to be exposed to streptococcal infection.

Reiter's syndrome, which is in some fashion associated with venereal contact, is not often diagnosed on older people.[10] Though the onset of Reiter's syndrome is usually before middle age, remissions occur in 50% of these cases and may be characterized by only part of the symptomatology of the original disease, i.e., arthritis alone. So an older male with rheumatoid-like arthritis not associated with rheumatoid factor in the serum may actually have chronic, recurrent Reiter's syndrome.[11] Similarly, *gonococcal arthritis* is not commonly seen in the aged.

2. Rheumatic diseases found in all age groups but presenting complicating features when occurring in the aged.

A wide range of diseases maintain their incidence in older people just as they do in other age groups. *Rheumatoid arthritis* is often thought to be a disease of middle age, but the onset, in fact, can occur even into the 80s and 90s.[12] With elderly patients, however, the tests for rheumatoid factor, which are often used to confirm the diagnosis of rheumatoid arthritis, may be positive in healthy, unafflicted people. About 15-20% of the over-70 population will have a positive test without evidence of rheumatoid arthritis.[13] The age of onset of *psoriatic arthritis* is not significantly different from that of rheumatoid arthritis.[14] Psoriatic arthritis rarely presents a diagnostic problem in the elderly since psoriasis characteristically has its onset before middle age and the chronic skin condition usually antidates the arthritis. *Polymyositis* occurs in the older age group and the likelihood of an associated carcinoma jumps from 15-20% in the under-40 polymyositis group of patients to 50% in the over-40 group.[15] Thus in older people, a diagnosis of polymyositis carries with it a mandate to search vigorously for a hidden tumor. *Infectious arthritis* by no means spares the aged population. Damaged, scarred, or chronically inflamed joints have less resistance to infection.[16] The same applies to debilitated or poorly nourished patients.[17] The aged have more potential contact with resistant or "hospital" organisms, especially penicillinase-producing staphylococci and coliform organisms.[18] Septicemia in the hospitalized elderly patient is common, and many have underlying joint disease. It should be borne in mind that the important early diagnosis of septic joint disease may be difficult because of sluggish immune responses which may mask signs of inflammation in elderly or debilitated patients.[17]

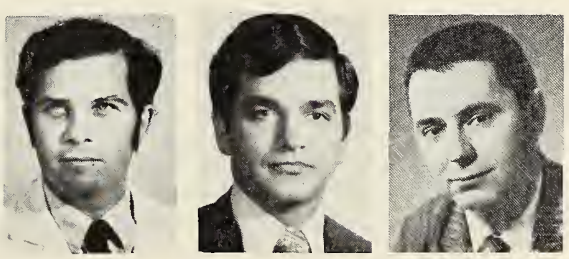
3. Rheumatic diseases which cluster in the older age group.

The increasing incidence of *osteoarthritis* with age is well known.[19,20] Studies of the joints of individuals in each decade of life show that changes in articular cartilage begin as early as the second and third decade and are almost universally present in the sixties and seventies.[21] The term "wear and tear" is often used to describe the characteristic pathological features of this disease, namely the softening, erosion and cracking of the articular cartilage. This leads to irregular narrowing of the radiological joint space and is associated with subchondral bone sclerosis and the formation of new bone growth at the joint margin. However, in contrast to these gross and histological findings are the pub-

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lished reports that indicate little or no age dependent changes in such parameters as chondroitin sulfate, hexosamine, water, ash, S^{35} uptake, even in specimens adjacent to pathologic cartilage, which theoretically are subject to the same wear and tear. In fact, even though osteoarthritis is classified as a degenerative type of joint disease, metabolic studies of articular cartilage show active synthesis of cartilage matrix.[22] These attempts at renewal offer hope that a more complete understanding of the underlying mechanism of this disease might allow more effective therapy directed toward stabilization or even reversal of the lesion.

In past years, it was common practice to consider the diagnosis of "mixed arthritis" for a select group of older patients who presented with features of osteoarthritis and rheumatoid arthritis. Although true rheumatoid arthritis can induce the secondary changes of osteoarthritis, this group of mainly middle-aged or older postmenopauseal women, developed both types of change simultaneously. Such patients have prominent Heberden's nodes at the distal interphalangeal joints and bony changes at the first carpo-metacarpal joints characteristic of osteoarthritis and, in addition, changes at the proximal interphalangeal joints. However, in contrast to the symmetrical soft tissue thickening found in rheumatoid arthritis, the proximal interphalangeal joints in these patients were marked by bony thickening in an asymmetric involvement. The term *"erosive osteoarthritis"* was introduced in 1966 to describe these patients.[23] In this entity, destructive bone erosions develop at joint margins and within the articulating surfaces of both the PIP and DIP joints. The pathology is generally limited to the hands and it lacks the systemic features found in rheumatoid arthritis (Table 1). Some deformity may result after the acute attack and fusion of the joint, but the disease is usually self-limited after a course of a few months to a few years.[24]

Chondro-calcinosis or *pseudogout* is an arthritic disease which usually affects large joints. It can run a gradual course similar to degenerative arthritis or be punctuated by acute attacks similar to acute gout.[25] On the X-ray, fine lines of calcification in the articular cartilage or menisci are pathognomonic. On examination of the joint fluid, crystals of calcium pyrophosphate can be seen. They can be distinguished from urate crystals using polarized light microscopy.[26] A few patients may have both gout with urate crystals and chondrocalcinosis with calcium pyrophosphate crystals. Thus, differentiation is important since long-term use of agents to control hyperuricemia as probenecid, sulfinpyrazone or allopurinol are needed only in gout and not in chondrocalcinosis. In addition, colchicine is not effective, whereas indomethacin or phenylbutazone usually give excellent relief. The disease usually occurs in the older patient. In one series the earliest age of onset was 54, with the majority of patients over 60.[27]

Polymyalgia rheumatica is a unique disease which occurs in older people. It is rarely seen before the age of 65 and has a 2:1 female to male incidence. The clinical picture is marked by muscle pain primarily about the shoulder and neck with involvement of the hips and legs

Table 1
Comparison of the Features of Rheumatoid Arthritis, Erosive Osteoarthritis and Osteoarthritis

Feature	Rheumatoid Arthritis	Erosive Osteoarthritis	Osteoarthritis
Morning stiffness	Marked	Mild	Unusual
Usual joints involved	Cervical spine, All peripheral joints	Distal and proximal IP, First carpo-metalcarpal	Distal IP, Weight-bearing joint
Subcutaneous Nodules	Yes	No	No
Common age of onset	20-40	45-55	50-60
Rheumatoid factor	80%	5-10%	5-10%
Elevated sedimentation rate	Usual	Minimal or none	No
Demineralization	Yes	No	No
Systemic Disease	Pulmonary, pleural, episcleritis, pericarditis, vasculitis, amyloidosis	No	No
Prognosis	Intermittently progressive, bone erosion, subluxation, ankylosis	Variably progressive, then quiescent, occasional fusion of IP joints	Slowly progressive, rarely crippling

as the second most common site. Transient joint symptoms may occur but are not the rule. The sedimentation rate is always significantly elevated.[28]

The uncomplicated syndrome has a good prognosis. Unfortunately, a high incidence of giant cell arteritis is associated with polymyalgia rheumatica. This complication, often called temporal arteritis, which also occurs in the older patients, can lead to blindness if it involves vessels of the eyes, even if not associated with the myalgic syndrome.[29] Because of this age-related phenomenon as well as the overlap of giant cell arteritis with polymyalgia rheumatica, some thought has been expressed that the underlying lesion of the muscular-connective tissue problem is vascular. Most physicians, on this account, recommend that steroids be given for as long as necessary to control the inflammation. This may require treatment for up to one or two years, after which the disease becomes quiescent so that indefinite use of steroid treatment is not usually necessary.

Osteoporosis is a natural process that occurs with age. It begins at about age 35-45 in women and about 10 years later in men and then increases in linear fashion.[30] In certain rheumatic conditions, as rheumatoid arthritis, this process is accelerated, but any type of arthritis in which there is partial disuse is likely to cause this complication. In some patients this can lead to spontaneous fractures when cortical bone had thinned sufficiently. Corticosteroids can predispose to osteoporosis at all ages, but this is even more important in the elderly.[31,32] Steroids, when indicated in therapy, probably should be administered in smaller amounts beginning with sub-therapeutic amounts that are gradually raised.

4. Special features in the management of diseases in older people.

A number of miscellaneous problems often complicate the management of rheumatic diseases of older people. One should be aware of their greater likelihood for trauma. Patients with arthritis who have difficulty getting about should be encouraged to wear proper shoes, to make sure that the pavement is smooth and not icy and to use a cane if necessary. Visual problems are frequent and the handicap of partial blindness with arthritis is a severe impairment. Peripheral vascular disease too, may be more frequent and pose diagnostic problems in the interpretation of pain in the extremities, besides causing a delay in the healing process.

Treatment of an elderly arthritic patient is not limited to the physical diseases alone. The social situation in this group is of even greater importance than in younger patients. Many are alone in the world or cannot depend upon their families for help. Their arthritic symptoms may impair ambulation, rendering them housebound. Consequently, they do not get out to visit friends or family and, unfortunately, they are not visited often either. Many arthritic patients require help in the simple activities of daily living, dressing, eating and bathing.[33] It should be obvious that the value of physical and pharmacological aspects of the treatment program for the elderly is enhanced greatly by a thoughtful social program.

Conclusion

It is very likely that many of the problems which afflict patients in older age have their roots in earlier years. Greater understanding of the biochemistry of disease, the changes in the connective tissue, the way the host interacts through his immunological mechanism with the environment may help prevent or retard some of the problems that become "degenerative" later in life.[34] Research is active in many of these areas. It is not unreasonable to hope that for coming generations, greater improvement in medical care of the arthritic problems of the aged should be achieved. Today, however, even with limitations on medical knowledge, more should be done to achieve a more exact diagnosis and to execute a careful therapeutic regimen. ◄

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Labor leads in political spending

Organized labor led in total political campaign spending last year, according to reports filed with the clerk of the House of Representatives. The AFL-CIO's Committee for Political Education was ahead of the top ten national groups reporting, with total spending of more than $967,000.

By Simon Horenstein, M.D./Missouri

Advances in the management of Parkinson's Disease

L-dopa has been found to most likely relieve features of paralysis agitans, post encephalitic parkinsonism. . . .

THE TERM "PARKINSONISM" is applied to a cluster of manifestations which occur in a variety of pathological states including the residuals of certain infectious disorders such as lethargic or Type A encephalitis, the "toxic" manifestations of certain drugs such as chlorpromazine, some residuals of hypoxia, the neurological consequences of chronic poisoning with manganese, certain consequences of hypertensive vascular disease affecting the nervous system and the prototypic disorder paralysis agitans itself. The manifestations of the parkinsonian state include rest tremor of the fingers, wrist and arm, rigidity, flexion dystonia and fixed attitudes, and an apparent elevation of the threshold to initiate, alter, and terminate movement, the so-called dyskinesia or bradykinesia. The manifestations of the disorder, as with all neurological abnormalities, depend upon the simultaneous release of certain nervous functions and the loss of others. The controlling and regulating mechanisms of the motor system are normally balanced against one another tending to result in a state of equilibrium which may then be altered by stimulation from without. Any disorder which affects these elements will then result in a biphasic clinical state of imbalance which reflects both excessive or unregulated activity of those otherwise normal neural structures which have been released from control and defective responsiveness to certain modifying influences owing to loss of function normally served by the affected structures. The former component, i.e. the overactive state, is usually the more obvious, and efforts at medical treatment have in the past usually been directed to modifying it, often with quite disappointing results.

The development of a treatment for Wilson's disease based on correcting a metabolic disorder opened an epoch in which disorders of movement would be approached by defining and correcting a biochemical defect rather than attempting to suppress an undesirable manifestation of released function. Since 1960, Hornykiewicz,[1] Barbeau,[2] and others have demonstrated and confirmed that dopamine is normally distributed in large amounts in the cells of the substantia nigra and the corpus striatum (putamen and caudate nucleus), being found in rather low concentration elsewhere. In the brains of patients with paralysis agitans, however, the story was rather different, as studies repeatedly showed evidence of depletion of this material in these regions. Loss of cells in the zona compacta of the substantia nigra and the appearance of intracytoplasmic inclusions (Lewy bodies) in others had been known for years. Moreover, subsequent studies made it apparent that the source of the dopamine in the corpus striatum was the cells of zona compacta of the substantia nigra from which the dopamine is believed to be transmitted by axoplasmic flow to nerve terminals near the cells of the caudate nucleus and putamen. It was thus inferred that depletion of dopamine as in chlorpromazine intoxication or loss of

cells in the substantia nigra as in paralysis agitans might have some bearing on the development of parkinsonian symptoms, and initial treatment trials were conducted with the racemate predecessor of dopamine, d,l-dihydroxyphenylalanine, since dopamine itself did not enter the nervous system upon oral or parenteral administration. Although the parkinsonian symptoms improved, significant toxic side effects made administration of the drug impracticable, and further treatment awaited separation and evaluation of the isomers.

Barbeau,[2] Cotzias, et. al.,[3] Yahr, et. al.,[4] and many others[5,6] have since demonstrated that the levorotatory isomer was both clinically effective and only slightly toxic, while the reverse was true of the dextro-rotatory form. Thus, l-dihydroxyphenylalanine (l-dopa) was introduced into the treatment of paralysis agitans and other parkinsonian states. The regularity with which the akinetic and dystonic manifestations of parkinsonism have been relieved, the ability to move with alacrity and nimbleness restored, and social function increased with only moderate and usually manageable side effect has led to its widespread prescription by physicians and acceptance by patients. The treatment, however, was not without its difficulties or pitfalls, and the object of this report will be to define the conditions for which l-dopa is most useful and suggest methods of management which have been most effective in our clinic.

L-dopa has been found to be most likely to relieve features of paralysis agitans, post encephalitic parkinsonism, and the neurological features of manganese intoxication. Additionally, favorable results have been claimed by some in the treatment of parkinsonian states associated with multiple cerebral infarction (so-called arteriosclerotic parkinsonism), phenothiazine induced parkinsonism, and dystonia musculorum deformans. In our own experience the agent has been most helpful in straightforward and uncomplicated cases of paralysis agitans. The less the major elements of paralysis agitans are present, the less likely the patient has been to display maximal benefit and the more likely toxicity to appear.

Paralysis Agitans or Parkinson's Disease includes four major motor manifestations which account for the bulk of disability. These are rest tremor, rigidity, fixed postures and attitudes, and difficulty initiating, arresting, and altering the rate and direction of movement (akinesia or brandykinesia). These elements are not always present to the same degree and may evolve in unique and distinctive patterns. The latter three features of the disorder often appear to be the ones which are most troublesome to the patients though not most obvious to others. Fortunately, they are the components which are most likely to be relieved by the use of l-dopa. The tremor may not only be little affected by the drug but may even become somewhat worse as the rigidity is lessened, tremor and rigidity often exhibiting a reciprocal relationship with one another.

Management of parkinsonism

The goals of management in parkinsonism have not been changed by the introduction of l-dopa though the distribution of therapeutic effort has. Our goals are:

1. To alleviate or modify the features of the illness with minimal toxicity.
2. To prevent complications resulting from manifestation of the disease or its treatment, including immobilization arthropathy, depression and lost social function.
3. To establish as simple a treatment regimen as possible using the smallest amount and number of drugs.
4. To assure the social and psychological well-being of the patient.
5. To manage associated illnesses.
6. To establish treatment objectives as the result of a contractual agreement with the patient.

The success of treatment of parkinsonism has always been difficult to assess. Various schemes have been designed to document lessening degree of tremor, stiffness of the limbs, or the speed of dressing. Such quantitative evaluations, while valuable in their own way, have always seemed to miss an important clinical point by failing to distinguish between what the patient CAN do and what the patient DOES do. The Foley question[7], "what does the patient DO that he did

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NOT DO before," must always be asked and answered in evaluating therapeutic effort. If the patient is no more active and independent after treatment it matters little whether he is slightly less stiff, and costly programs become insignificant.

The preparation of the patient for treatment with l-dopa depends upon assessing his general health, establishing that normal mental function is present, ascertaining whether a pulmonary, renal, myocardial, or cerebral infarct has occurred within the two weeks prior to initiating treatment with l-dopa, and identifying other drugs which he may be taking or may be required to take in the future, particularly monoamine oxidase inhibitors and sympathicomimetic amines.

It is our practice to survey hematopoietic, renal, hepatic, cardiovascular, and pulmonary systems. This is accomplished by obtaining hematocrit, hemoglobin, white cell count and blood smear, urinalysis, creatinine clearance, blood urea nitrogen, serum protein and protein fractionation, alkaline phosphatase, SGOT, LDH, serum bilirubin, two hour post prandial blood sugar, NA^+, K^+, CO_2, Cl, electrocardiogram, chest X-ray and blood pressures recumbent and after standing for five minutes. When the history or appearance of the patient so indicates, endocrine (especially thyroid) function is assessed. Any visual symptom should be explained and if ocular tension and gonioscopy have not been performed recently they should be to exclude untreated narrow angle glaucoma. Neurological assessment includes detailed history and evaluation with regard to mental state and intellectual function. The spinal fluid, brain scan, electroencephalogram, and skull X-rays are studied.

A simple rapid program of drug administration tolerated by most patients begins treatment with l-dopa by the administration of 0.5 gm two to four times during the first day. Of those who can tolerate this dose a large number will experience improvement quite rapidly. Since this rather large initial dose may provoke gastrointestinal side effects, it is usually handled best by hospitalization, thus facilitating monitoring the patient. The drug may then be increased by 0.5 gm to 1.0 gm every second or third day until the patient improves no further or has begun to show some new motor manifestation such as facial chorea. At that time the dose may be reduced slightly or modified with pyridoxine (see below). L-dopa is never given in excess of 8.0 gm. Few patients require 6.0 gm and most stabilize at 4.0 to 4.5 gm. It has been our experience that the majority of patients can be treated in this fashion, tolerating the drug rather well and achieving therapeutic levels quickly. Few patients will continue to require the initial dose and reduction of the amount prescribed at the time of discharge by 0.5 to 1.0 grams is common. Hospitalization requires 10-14 days. It has been our practice to allow comprehending patients to arrange the time and size of dose in terms of their own responses beginning in the latter days of hospitalization. Since pyridoxine accelerates the decarboxylation of dopa, it should be avoided in all forms except that normally in the patient's normal diet. Substances containing this vitamin include some fortified breads and flours, and if they are part of the patient's normal food intake, they should be kept stable. At the present time dopa decarboxylase inhibitors are not available for general use but it is highly likely that the next "generation" of biogenic amine treatment of parkinsonism and related disorders will involve the use of such a compound. This agent will enable the patient to be treated with smaller amounts of l-dopa by delaying the drug's metabolism.

In the event that the patient for one or another reason discussed below is unable to tolerate rapidly administered l-dopa, the compound may be administered more slowly using a dosage schedule which begins at .250 - .750 gm daily and attains 4.0 - 5.5 gm daily over 6-8 weeks. The compound can be increased slowly, continuously, and at a rate equivalent to the patient's tolerance. In some cases increments may be as small as 0.125 gm every three to five days. In other cases patients may be left on .250 - .500 gm daily for three to four weeks before the next increase, and some individuals require as much as three to six months before attaining a therapeutic level. When dopa is administered slowly hospitalization is not required for the entire period, but we prefer to observe patients closely during the initial 10-14 days. Maintaining such patients on low doses for several weeks appears to lessen toxicity and larger doses may later be tolerated with little difficulty. Some have reported that patients may actually require less drug. Treatment thus requires individualization based on response. It is our practice to start on

the rapid treatment schedule as it ordinarily becomes evident at the onset which patient will require the slower or more highly individualized program. L-dopa is available in scored 0.25 gm and 0.5 gm tablets so that doses as small as 0.125 gm may be prescribed. It is also available in .25 gm and 0.5 gm capsules.

Relief of rigidity

The anticipated results of treatment are relief of rigidity, release from fixed postures and attitudes, and the restitution toward normal or more nearly normal patterns of movement. In the opinion of this author, the single most common, important, and striking feature in the patient who is benefitted is improved capacity to initiate, sustain, alter, and terminate movement, and this aspect of parkinsonism appears by far to be the most important source of disability. Thus, if one views the immobility of parkinsonian patients as derived mainly from their inability to move in the broadest sense, this effect of dopa accounts for the rapidity with which it has superseded other forms of drug treatment. Most patients note improvement in axial motor function as the initial change and frequently this comes as early as the first day of treatment. Turning or flexing the trunk, especially while in bed or attempting to rise from a chair and retroflexion of the shoulder as in dressing or attending to personal hygiene may occur before the patient has had conspicuous improvement in gait or handwriting. Shortly after the appearance of improved mobility of the trunk and shoulders, facial expression, vocal volume, speech and swallowing become more normal. Frequently this is expressed by intelligibility when using the telephone for the first time in months or years. The effect on tremor is highly variable, but in many cases tremor is actually increased even though other manifestations are lessened. This is not ordinarily taken by the patient as a cause for rejection of the drug as the increased tremor may coincide with increased motility. It is, however, very difficult to predict accurately which changes will occur and whether they will assume a given sequence.

Continuing care of the patient on dopa after hospitalization should be individualized but in general one prefers to see patients at least twice a month for the first two months as this is the period in which alteration in treatment may be needed. An occasional patient may develop nausea and hypotension during this period and require drastic dose reduction and slow increase again. It is also a period in which the motor side effects discussed below may emerge. In the first month or six weeks blood count, urinalysis, and the basic laboratory parameters should be repeated. The BUN, SGOT, LDH, bilirubin or alkaline phosphatase may be raised without other evidence of renal, hepatic, or cardiac disease and there may appear to be ketones in the urine if the common paper spot test is used, or uric acid if the usual colorimetric methods are employed. Mild leukopenia may also occur, but even though the drug is continued this returns to normal. The Coombs test becomes positive rarely. For the next few months the patient should be seen monthly, and the blood count, urine, and basic laboratory parameters checked bi-monthly. After six months, the patient is seen at three month intervals, with re-evaluation of his laboratory parameters.

Adverse reactions and L-dopa

Adverse reactions attributed to dopa have been reported in virtually every organ system but many of them appear to be trivial and contradictory. Both constipation and diarrhea, for example, have been ascribed to dopa. Other complaints attributed to dopa are common features of parkinsonism such as blepharospasm. Still others appear to be the result of suggestion, including both sedation and stimulation. Another group would appear to reflect incompetent or superficial medical evaluation such as dementia. The following paragraphs will consider those adverse reactions which are common, clearly related to the drug, and of significance in management.

The commonest side effects of l-dopa and among the most important causes for rejection by the patient are nausea, vomiting, and paroxysmal vertigo or faintness with or without orthostatic postural hypotension. Symptoms ordinarily begin between 20 and 45 minutes after taking the dopa and are thought to represent a direct effect of the drug on the brainstem rather than a pharmaceutical peculiarity. The symptoms frequently are relieved by administering the drug during or just after meals. Atropine or trihexiphenidyl taken one-half to one hour before the dopa may also provide relief. Antacids have not been useful. An occasional patient who is intolerant to dopa may recover from his gastro-intestinal symptoms if the drug is given in very small amounts (.125 - .25 gm/day) over several days or a week or two.

Orthostatic postural hypotension is relatively common but subjective accompanying complaint

is rather infrequent. Hypertension is rather infrequent but both forms of altered blood pressure are self limited and short-lived. Neither is a cause for stopping the l-dopa. Occasional darkening of exposed areas of the skin, dark or peculiar smelling sweat or urine and a body odor which is described as somewhat fishy, are occasional side effects and do not constitute major problems. Cardiac rhythm has been altered in a few patients who have developed transient tachycardias or multiple premature ventricular contractions. These, too, tend to be self limited.

Inability to swallow constitutes a major problem in the initiation of treatment with l-dopa in some patients but as the patient begins to improve this usually lessens. When severe dysphagia is present the nursing service or family should be instructed to look in the pharynx for evidence that the pill or capsule has been swallowed. If necessary, the powder or crushed tablet may be dispensed in gelatin or jam and thus administered. We have never found it necessary to intubate a patient in order to initiate dopa therapy.

Major psychological disorders in parkinsonian patients receiving dopa are most uncommon though agitation, anxiety, confusion, delirium, and depression have all been described.[8,9] One's own experience has been that the patient who exhibits the aforementioned manifestations, especially confusion and delirium, is likely either to have had an antecedent emotional disorder or to suffer some illness other than or in addition to parkinsonism. Senile dementia with altered motility and the pseudoparkinsonian effects of hypertension and cerebral atherosclerosis are conditions most likely to be erroneously treated with l-dopa resulting in a major disorder of behavior. Minor psychological reactions are common in paralysis agitans. That most frequently observed in our own patients has been vivid dreams which are recalled in great detail, and owing to the fact that they are often followed by rapid arousal rather than a period of slow wave sleep, are poorly differentiated by the patient from reality. The dreams are often hostile or angry and tend to be recurrent.

Changes in libido have received a good deal of publicity but there is no convincing evidence that these are direct results of the drug. They are believed for the most part to represent instead a secondary effect of general improvement in well being.

By far the most annoying, persistent, and discouraging side effect of the administration of l-dopa is the emergence of new signs of altered motor function especially abnormal movements about the face, lips, tongue, and jaw, intermittent periods of postural fixity, dystonia, or uncontrolled restless movements of the limbs, especially the legs.[10] In many instances these episodes occur in the evening or after sitting still as at a desk for several minutes to an hour. These symptoms sometimes respond to reducing the total daily dose slightly, but occasionally the degree to which the dose must be reduced also minimizes the effectiveness of the drug. In some patients in whom the episodes are predictable rearranging the time of medication with an evening or bedtime dose or alternatively prescribing small amounts of pyridoxine (10-25 mg) one hour or so prior to the anticipated attack may give relief. In other patients l-dopa may be slowly withdrawn until the movements disappear and the patient then maintained at a lower dose. Occasionally the addition of small amounts of amantadine HCl, benztropine mesylate or trihexiphenidyl is helpful but the sad fact is that an occasional patient remains who simply is not helped by any of these measures and who may be so uncomfortable that he rejects the l-dopa. A minor degree of postural fixity or dystonia is, however, rather common in the toes where plantar flexion or other abnormal position may occur and result in erosion of the skin of the toes by abrasion against the inner shoe. This condition is rather difficult to eliminate and the use of shoes with larger toe boxes, flat shoes in women, and protective padding are usually required.

The fact that patients are receiving l-dopa should not modify other aspects of the program of care of the parkinsonian, especially the need for a proper program of activity and exercise designed to maintain muscle tone and physical endurance, emphasizing mobility of the hips and shoulders and flexibility of the wrists and fingers. These programs should be taught the patient who is as responsible for their implementation as he is for taking his medication. Relatively few parkinsonian patients who have given up their work return to it despite treatment, though all patients augment their activities. A plan of management also requires the provision of opportunities for socialization which offer the pa-

(Continued on page 535)

By Bertram B. Moss, M.D./Chicago

Normal aging

Oldsters are preoccupied with themselves because they soon realize that practically no one else is. . . .

THE DIFFICULTY OF differentiating normal aging from physical disease co-exists in attempting to separate normal elderly emotional changes from mental diseases. We know that many old people characteristically are a catalogue of a multiplicity of physical ailments but we often forget that they also have many emotional problems.

A common frustration of professionals who deal with the elderly is that of distinguishing the physiological from the non-physiological complaints. Their insistent need for attention and inability to properly communicate are well known. A good number of the elderly are depressed, and for good reason. The plight of the elderly is reflected by the masses who cannot hide the guilt and hostility they feel for the aged. The oldsters themselves feel the loss of memory for recent events and the great loss of their special senses—particularly hearing, seeing, taste, smell and sexual. They are preoccupied with themselves because they soon realize that practically no one else is. Their sensory losses are compounded by their many physical and actual social losses such as loss of loved ones, status and independence.

The insecure status of the elderly is what leads to the often found confusion. We note that the confusion is exacerbated by new demands, such as a change in domicile, or a change in room. The security of even a marginal adjustment is always threatened by new demands with diminished reserves and capabilities to respond. It can be environmental or even a physical alteration which calls for reserve forces often in short supply. This is not to exclude the physical defects producing mental aberations from such things as lung pathology, circulatory disorders, nutritional defects, plus hormone, chemical or toxic pathology. The toxic psychosis or acute brain syndrome seen in delirium following intoxications, trauma or acute illness is but another manifestation of inability to accommodate to the new demands.

A great deal of the visibly peculiar mentality of many old people stems from the medications they are often taking. Not only are there paradoxical effects of certain medications but the mood elevators, or depressents or tranquilizers present an abnormal mental status, especially confusion.

Normal mental changes

There are certain normal mental changes which occur in people with age. A memory loss for recent events is almost universal. A high

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percentage of older people exhibit a slowness in novel problem solving. They do eventually note a weakness of creative imagination. Restlessness and/or disturbances of sleep are quite common among elderly persons. Intelligence performance more than verbal performance intelligence test, diminish in score as people age. Transient ischemic episodes do produce some emotional aftermath. This is even more noticeable among those old persons who have some underlying anemia, cardiac decompensation or arteriosclerotic changes. Cardiac arrhythmias as well as embolic or hemorrhagic phenomenon of the brain are accused of producing peculiarities of mental functioning. Electrolytic changes relative to dehydration, drug induced or even nutritional toxicities as well as azotemia and hormone changes, are notorious for producing mental aberations. Epilepsy with post-seizure amnesia, as well as central nervous system infections or liver diseases will also produce some bizarre behavior. Certainly brain tumors and/or hemotomatae will give an abnormal mental picture. The use of narcotics as well as barbituates and even the withdrawal symptoms from such medications can produce abnormal psycho-medical responses.

Organic vs. neurotic

Symptoms of varying degree form a multiplicity of organic defects which are often difficult to differentiate from neurotic mental mechanisms. The elderly hypochrondriac usually has a long history of medical complaints with over-concern for medical matters. Traditionally a variety of organ systems are involved. The psychoneurotics on the other hand, may have a persistent or long history, but usually there is a localization of organ systems for their complaints. Many times obsessive complaints relative to one organ will persist. The malingerer exhibits the symptoms of a conscious deception which can usually be detected with experience. Depression can be a defense against true sadness. Most old people have many things to be sad about. It is mandatory to slow down to the pace of the elderly. We must somehow find the time to listen to their complaints or their expressions.

Even though they are usually made dependent when institutionalized, we must make every effort to meet their dependency needs (which is usually the reason for their institutionalization) and at the same time try to encourage their remaining independence. The keynote of all programs for the institutionalized aged is to encourage both physical and mental functioning. We often overlook the fact that less than five percent of all people over the age of 65 have to be institutionalized. Only five percent of the aged are unable to exist in the general community because of some dependency need. This need is not always a medical one, for it may be an inability to shop for food, to dress or cook. The accumulated experiences of the elderly usually prepares them to detect sincere warmth and affection. Time has permitted them to become sensitized to a patronizing attitude. They recall their status and their accomplishments even though those who deal with them daily may not. Our parents are not our children and they must not be dealt with as if they are babies.

"Fading" rates

One of the most important findings to date in the "new science" of gerontology is the observation that different parts of the body resist aging more than others and that our various abilities fade at different rates. The replacement of elastic tissue by inelastic fibrous cells is both frequent and widespread. Some researchers believe that, if there is a "process of aging," it is probably represented by this change in connective tissue. With aging, restorative, replacement, and resistant capacities of some cell forms tend to be reduced. There is a reduction of cells numerically but this is compensated for with the accumulation of cell properties from exposures and additional cell activities which compensate. The ratio of working cells to resting cells increases. Body capacities in aging are reduced in proportion to cell changes.

"Normal abnormalities"

Those who deal with medical problems of the elderly must be aware of the *"normal abnormalities of aged persons."* It is not presumptive of diabetes to have only one elevated fasting blood sugar in an elderly person. A blood urea nitrogen may be "normally" elevated in an elderly person.

The Public Health Service reported in 1966 that so many changes come with age to so many people that the changes can hardly be termed abnormalities. Yet, it is hard to say how much of these changes can be attributed to intrinsic aging and how much to pathology. Disease and other environmental agents undoubtedly have effects indistinguishable from intrinsic aging. And the relationship of intrinsic aging to clinical disease is generally considered to be indirect; the biological degenerations of aging may con-

fer vulnerability to disease. Thus, the etiology of pneumonia is bacterial or viral, but the increased prevalence of pneumonia as the third leading cause of death among the elderly suggests increased susceptibility. Most age-related diseases are degenerative, and lack a distinct dominant cause. Most common in old people are sequelae of arteriosclerosis, involving a variety of organs.

If the mean health values of the young were taken as the general norms of health, most of the elderly would have to be considered ill. Aging brings quantitative rather than qualitative changes in performance.

Certain functions show little or no significant change with age; others change during the fifth or sixth decade and stabilize. Still others remain essentially unchanged until relatively late in life and then slowly decline. Finally some processes begin to decline during the third and fourth decades and the declines slowly gather speed. Certain functions decline early in life but the decline is obvious only under heavy stress.

As for the hemopoietic system, there is little information on aging changes in the bone marrow. There is some evidence of a diminution of functional and reserve capacity which becomes evident only under stress. Thus there is a diminished leucocytic response to infection and a retardation of recovery from anemia due to hemorrhage.

Love and understanding

It is necessary for the elderly to be reminded that they have certain obligations. Love is not automatic, it must be earned. We do have a responsibility to show concern and attention and respect for all old persons, but that little extra something called love is what makes the difference in the administration of sincere "tender, loving, care." The old people have to be advised of the value of being active both physically and mentally, as well as being congenial and understanding of those who are doing what they can for them. It is often necessary for the old people to re-learn, if not to learn for the first time, how to get along with the society they find themselves in.

The major difficulty is that we are still the first generation privileged to deal with so many elderly people at one time, particularly in institutions. We are learning from our own trial and error methods. Very few of us had any professionals available to teach us about old people. Our first step is to acquaint ourselves with what we now know to be normal both physically and mentally for older persons.

To work is deemed good; to not work is thought to be bad. The elderly do not work, and therefore they (and many others) think of themselves as being no good. We want everyone to enjoy liberty and to express themselves and be as good as the next one, but old people are not included. Even in our enlightened period of acknowledging sexual needs and changing morality, we are not yet permitting the elderly to satisfy their sexual drives. We do not frown upon cocktails for adults and we are diminishing our disdain for tranquilizers for the nervous, or "pot" for the young. We condone these drugs for people to function as they wish, but when dealing with elderly persons we utilize drugs to make them "adjust" to our demands.

Death in stages

We all must face the fact that many old people are soon to die. Many of them will achieve comfort in discussing this inevitability with some one. Quite a few elderly people claim that it is very comforting to discuss what is truly bothering them, and what is truly keeping them awake at night. Most know they are about to die and they do get relief in discussing it.

Dr. Elizabeth Kuebler-Ross has outlined the stages of dying from an emotional viewpoint. To understand these is to enable one to work with those who are dying. It is normal for those one who feel that they are soon to die to deny the fact. The denial may soon turn to anger or resentment which is understandable when they ask themselves why this is happening to them. The next stage is usually one of bargaining where they will either attempt to bargain with God or themselves in an attempt to avoid or postpone the death. The unsuccessful bargaining usually turns to depression. This is a dangerous stage, as suicide which is so common among elderly is a great possibility. The final stage is the stage of acceptance or passivity. It is this latter stage that the experienced nurse usually senses and recognizes in those soon to die. ◄

By James R. Durham, M.D. and Elizabeth T. Bailey, R.N.

Nursing Home: Medical director's role

THE MEDICAL DIRECTOR may not be full time, but he must meet regularly with his administrator and head nurses to formulate the general medical plan, and check to see that it is operating properly. Each resident is, of course, cared for by his own physician who may need some prodding at times to see his patients periodically.

The medical director also must see that an "on call" list is available and that some physician is easily available and responsive to nursing home needs.

If the nursing home is covered by Medicare, the medical director has to see that a Utilization Review Committee is appointed and functions properly with regular reviews and recorded meetings.

A good nursing home administrator is invaluable to the over-all plan and responsibility for good medical care. He should be an overseer of the care given by each doctor of the attending staff, and assure the proper recording of this on the individual history records.

The general nursing plan is formulated by the administrator and the medical director with their head nurses. Each resident should be analyzed as to his care, time, and rate, in order to determine how many nursing hours a day he needs for good total care and rehabilitation. The nursing home should not always be a place of last residence, but a rehabilitation center from where many patients go home. *(Note: Early transfer of patients from the local hospital to the nursing home will more likely be covered by the intermediary for Medicare.)*

Liaison between local physicians, hospital medical staffs, and medical societies is another area where the medical director is quite valuable. Letting doctors know the needs and aims of the nursing home and letting the nursing home know how doctors may give better service cannot help but improve patient care.

A medical director should be a required consultant in the operation of all nursing homes. However, he must be an active participant in the supervision of care of nursing home residents, and not merely a figurehead or "rubber stamp" in the nursing home operation.

In summation, the general return of medical care responsibility to physicians through the medical director will help improve all nursing homes.

The following are Illinois Department of Public Health rules and regulations regarding "Medical and Personal Care of Residents" as revised by that Department September, 1971.

DIVISION 5—MEDICAL AND PERSONAL CARE OF RESIDENTS

05.01.00.00 Section 1—Medical Care Policies

05.01.01.00 The administrator shall have a written program of medical services that reflects the philosophy of care provided, the policies relating to, and the procedures for implementation of these services. The program shall include the entire complex of services provided by the facility and the arrangements to effect transfer to other facilities as promptly as needed.

Additional for Intermediate Care Facilities

05.01.01.01 *There shall be an advisory physician or a medical advisory committee composed of licensed physicians who shall be responsible for advising the administrator and the licensee on the overall medical management of the residents in the facility. If the facility employs a house physician, he may function as the advisory physician. The written program of medical services shall also include the structure and function of the medical advisory committee, if the facility has one.*

Additional for Skilled Nursing Facilities

05.01.01.02 *There shall be a medical advisory committee composed of two (2) or more licensed physicians who shall be responsible for advising the administrator and the licensee on the overall medical management of the residents in the facility. If the facility employs a house physician, he may be one member of this committee. The written program of medical services shall also include the structure and function of the medical advisory committee.*

05.01.02.00 The services of a physician licensed to practice medicine in Illinois shall be available to every resident of the facility. Residents in facilities operated under the bona fide Christian Science auspices may be exempt from this requirement.

05.01.03.00 The resident or his guardian shall be permitted his choice of a physician. The physician shall visit the resident as often as necessary to assure adequate medical care.

Additional for Intermediate Care Facilities

05.01.03.01 *The resident shall be seen by a physician at least every three months.*

Additional for Skilled Nursing Facilities

05.01.03.02 *The resident shall be seen by a physician at least monthly.*

05.01.04.00 Each resident admitted shall have a complete physical examination either prior to admission or within seventy-two (72) hours after admission to the facility. This examination shall include an evaluation of the resident's condition and recommendations for his care including personal care needs and permission for participation in the activity program. (See 09.01.03.00)

05.01.05.00 If the facility cares for mentally retarded persons or discharged psychiatric patients, approved professional consultation, as indicated in 04.02.01.00, shall be provided.

05.01.06.00 The facility shall notify the physician of any accident, injury, or unusual change in a resident's condition.

05.01.07.00 At the time of an accident, immediate first aid treatment shall be provided by personnel trained in medically approved first aid procedures.

Additional for Intermediate Care Facilities and Skilled Nursing Facilities

05.01.08.00 *The admission information for a resident shall include current medical findings, diagnoses, rehabilitation potential, a summary of the course of treatment followed in the transferring institution, and orders from the physician for care of the resident. If this information is not received with the resident at the time of admission, it must be received within forty-eight (48) hours.*

Additional for Skilled Nursing Facilities

05.01.09.00 *All admissions to the facility shall be upon the recommendation of a physician.*

JAMES R. DURHAM, M.D., is a general practitioner in Mendota and Medical Director of Sunrise Nursing Home there. He received his M.D. degree from Yale Medical School.

ELIZABETH T. BAILEY, R.N., is a licensed hospital administrator. She received her R.N. at St. Luke's Hospital in Chicago and her M.A. in hospital administration from Northwestern University.

Nursing Home

05.02.00.00 Section 2—Personal Care

05.02.01.00 Each resident shall have proper daily personal attention and/or care including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

05.02.02.00 Each resident shall have at least one (1) complete bath and shampoo weekly and as many additional baths and shampoos as necessary for satisfactory personal hygiene.

05.02.03.00 Each resident shall have clean suitable clothing in order to be comfortable, sanitary, free of odors, and decent in appearance.

05.02.04.00 Each resident shall have clean bed linens at least once weekly and more often if necessary.

05.02.05.00 Each resident shall have sufficient clothing, in good condition, to be properly dressed each day.

05.03.00.00 Section 3—Communicable Disease Policies

05.03.01.00 The administrator shall assume the responsibility for meeting all the *Communicable Disease Rules of the State of Illinois, Department of Public Health,* so that there is a minimum danger of transmission of contagious, infectious, or communicable diseases.

05.03.02.00 No resident with a communicable, contagious, or infectious disease shall be admitted knowingly. An individual, when suspected or diagnosed as having any such disease, shall be placed in isolation in accordance with the rules and regulations of the Illinois Department of Public Health until removed from the facility.

05.03.03.00 No resident shall be admitted knowingly who has had a history of tuberculosis until the resident is classified as inactive as defined by the latest classification of the American Thoracic Society, "Diagnostic Standards." (See Appendix B for criteria for the admission of a person with a history of tuberculosis.)

05.03.04.00 All illnesses required to be reported under 05.03.01.00, above, shall be reported immediately to the local health department and/or to this Department. The administrator shall furnish all pertinent information relating to such occurrences.

05.04.00.00 Section 4—Psychiatric Emergencies

05.04.01.00 If a resident becomes disturbed or unmanageable, he shall be examined by his physician and/or by a psychiatrist. This medical examination shall be carried out promptly.

05.04.02.00 Upon the direction of a qualified physician or physicians, the facility shall have the right to discharge to an appropriate resource, any resident or residents for whom such action is indicated.

05.04.03.00 No form of seclusion shall be permitted, even if the resident desires it.

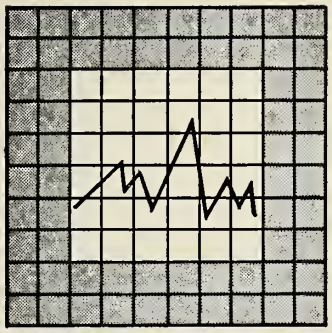
Additional for Intermediate Care Facilities and Skilled Nursing Facilities

05.04.04.00 *Restraints shall be used only in an emergency and only upon a physician's or psychiatrist's order until the resident is examined by one or both of them. This examination shall be carried out promptly. Restraints may be applied only by personnel trained in proper application and observation of this equipment.*

05.04.05.00 *The reason for ordering and using restraints shall be recorded in the clinical record. There shall be written policies covering the use of restraints.*

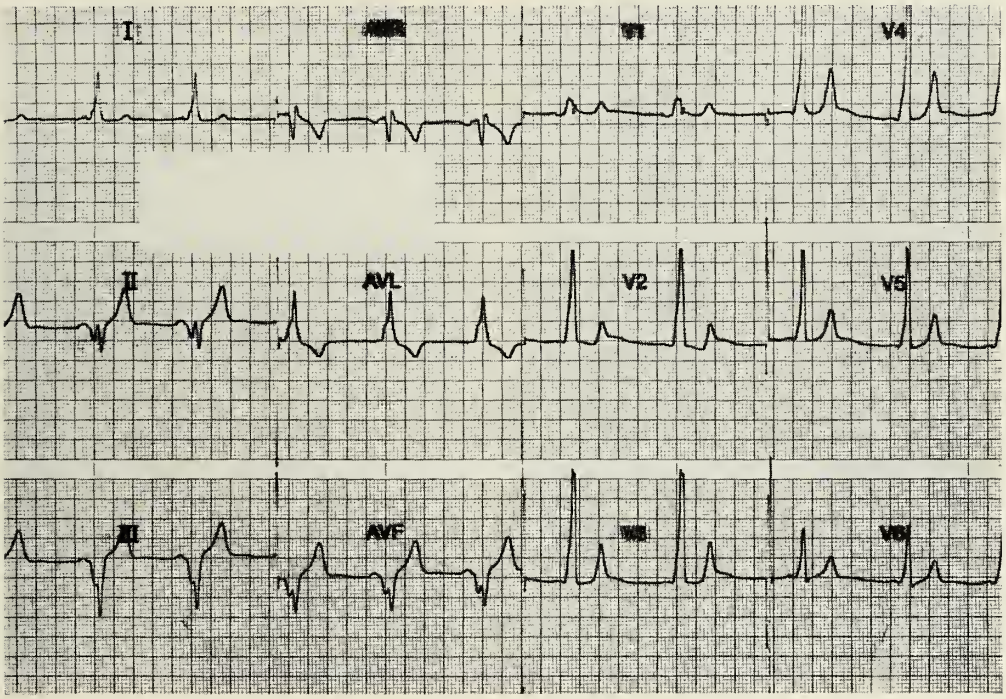
The "two" go together

"Profit and social progress go together, and in our free economy are inseparable. The job of business is to provide the consumer with goods and services with the most satisfaction at the lowest economic cost." —James M. Roche, chairman of the board, General Motors Corporation.



ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D.
and Patrick Scanlon, M.D./Section of Cardiology,
Department of Medicine
Loyola University Stritch School of Medicine



A 30-year-old accountant was seen in the office complaining of left precordial pain present for the past year. It occurred once or twice a month, was unrelated to activity, would last a few minutes and would spontaneously subside. The examination was unremarkable except for a loud first heart sound.

Questions: (One or more of the choices may be correct.)

The electrocardiogram showed:

1. Right bundle branch block, complete.
2. Inferior wall myocardial infarction, probably acute.
3. True posterior myocardial infarction, old.
4. Hyperkalemia
5. None of the above

(Answer on page 540)



surgical grand rounds

Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 18, 1970.

Edited by John M. Beal, M.D.

Marjolin's ulcer

Case Report:

Dr. John Eilert: A 58-year-old, Negro male sustained a gasoline burn to his left leg as a child, which required skin grafting. This was followed by repeated grafting, ulcer formation and repeated biopsies of the ulcers. Several months prior to admission, he noticed "bumps" in the scars, which had not been present previously. He was admitted to the hospital for biopsy and treatment.

Physical examination was unremarkable except for the left lower extremity. The left leg was involved by a nodular irregular scar that was nearly circumferential and ulcerated in several areas (Fig. 1). A hard, 2x4 cm. inguinal node was fixed to the skin of the left groin and there was diffuse swelling of the left lower extremity. Laboratory findings, including chest X-ray and electrocardiogram, were unremarkable.

Biopsy of the inguinal node and the leg ulcers was performed. X-rays of the left lower leg were obtained.

Dr. Harold Matthies: There is a sclerotic area in the tibia at the level of the lesion (Fig. 2). This has the appearance of reaction to the infection of the overlying skin, aseptic bone sclerosis beneath an infection. There isn't really true



Fig. 1. Nodular areas in the lower portion of the scar were found to be malignant.

periosteal reaction. The periosteum has laid down bone, but it is very compact bone, not laminated, and it appears to have gone on for a long time. This does not have the appearance of neoplastic involvement. There is also some periosteal reaction in the fibula. A similar appearance is seen in cases of long standing venous congestion of the leg. Again, I don't think I would be suspicious that there was a malignancy of the bone.

Dr. John Beal: What about osteomyelitis?

Dr. Matthies: There is a benign sclerosing of the type known as sclerosing myelitis of Garre, but not related to infection overlying the bone.

Dr. Eilert: Liver scan and liver function studies were normal. Amputation of the left leg was performed above the knee because carcinoma was present in the ulcers. Three weeks later, a left groin dissection was performed because a lymph node was found to contain carcinoma when biopsy was performed. The patient recovered well although he developed a urinary tract infection as a result of an indwelling Foley catheter which was kept in place during the post-operative period.

Dr. Wilbur Franklin: Cancer arising in burn scars was first described by Marjolin in the early nineteenth century. Since that time the lesion has taken his name. A number of well defined histologic changes occur in association with carcinoma of a burn scar. In response to the burn injury, the epithelium of the skin undergoes

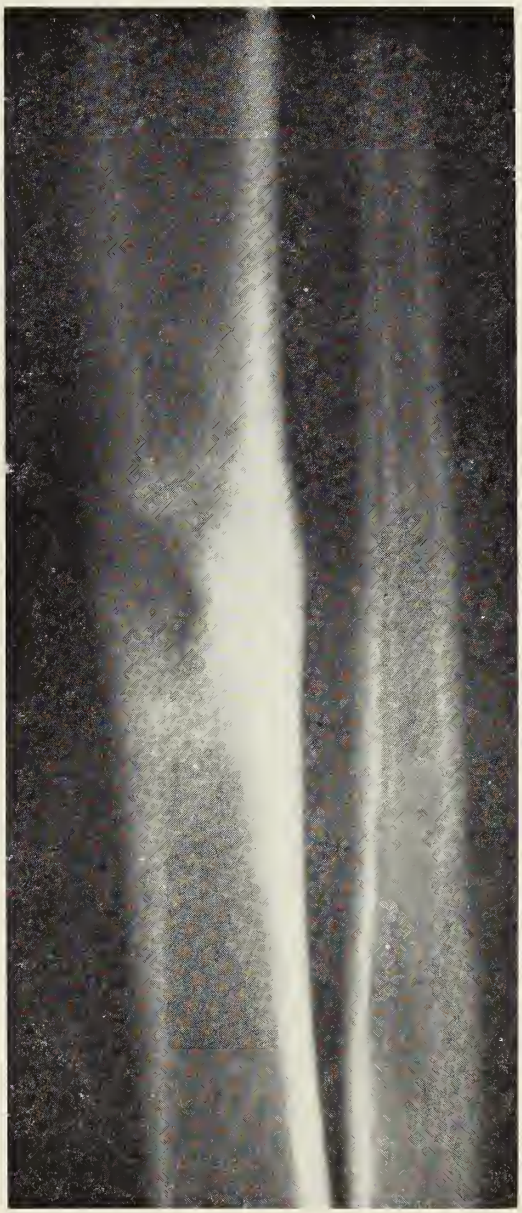


Fig. 2. Sclerotic area in the tibia beneath the ulcer on the leg had the appearance of reaction to infection.

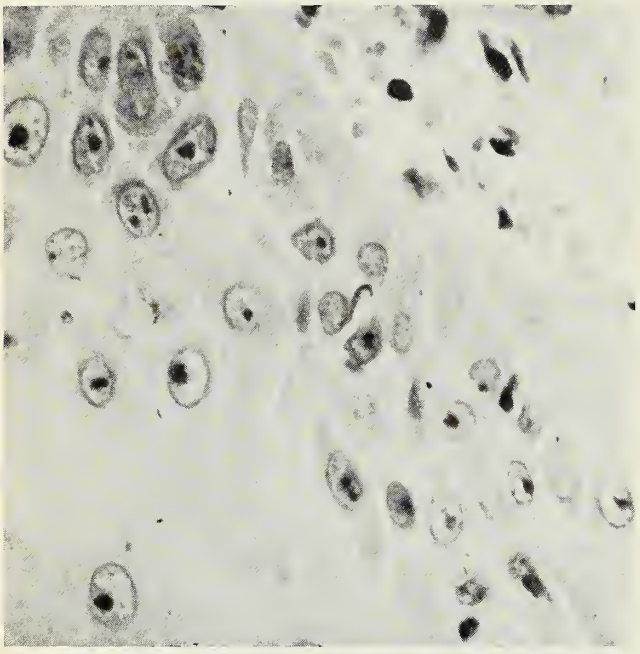


Fig. 3. Photomicrograph of skin showing well differentiated squamous epithelium in pseudoepitheliomatous hyperplasia.

thickening in the Malpighian layer. A more virulent hyperplasia of the epithelium may supervene, which is sometimes difficult to distinguish from squamous cell carcinoma and is called pseudoepitheliomatous hyperplasia. In rare instances pseudoepitheliomatous hyperplasia is accompanied by the development of squamous cell carcinoma. This patient illustrates these changes well.

Early biopsies show marked inflammatory changes in the dermis and thickening of the Malpighian layer of the epidermis. In some areas, the rete pegs extend deeply into the dermis and present the features of pseudoepitheliomatous hyperplasia. However, there is little cellular atypia or disturbance of maturation sequence (Fig. 3). At a later stage, biopsies show circumscribed hyperplasia with abundant keratin formation.

Squamous cell carcinoma was first discovered in this patient at the age of 56. The biopsy now reveals irregular islands of epithelium deep within the dermis. The cells within these islands display loss of polarity, marked pleomorphism, increase in staining properties of nuclei and a disturbed maturation sequence (Fig. 4). Some of the cell nests contain central accumulations of keratin. A second portion of skin containing squamous cell carcinoma was removed from the patient at age 57. This brings us to the present admission when squamous cell carcinoma was found in the skin and in 19 of 20 popliteal and inguinal lymph nodes.

Dr. Paul O'Brien: Historically, Celsus associated chronic neglect of burns with the development of skin cancer in the first century, but Marjolin specifically associated development of epidermoid cancer following burns. Marjolin ulcers, therefore, are not applicable to epidermoid carcinoma developing in pilonidal cysts or in the chronic sinus tract of an old osteomyelitis. Most of the cancer which develop are epidermoid, approximately 8:1. Allegedly, the basal cell cancers develop when the burn is more superficial and the hair follicles and sebaceous glands have been left intact. Deeper burns, for example direct flame burns, usually develop epidermoid carcinoma. This is a rare cancer and, in our seven thousand recorded cases at Northwestern over the past five years, we have five cases, two of which are questionable.

The average delay between the initial trauma and development of the cancer in Dr. George Pack's group of 30 patients was 32.5 years. There seems to be an age relationship, the younger the patient at the time of the burn, the longer the period of time prior to the development of the skin cancer. Most *de novo* primary skin cancers, the usual epidermoid carcinomas that we find in the face, feet, etc., do not present with lymph node metastasis as frequently as do the epidermoid carcinomas developing in old burn scars. Positive nodes in these patients are present in approximately 35% while in primary epidermoid skin cancer, positive nodes are not found in more than five per cent of patients.

This is preventable cancer. Dr. Eilert referred to the lymph node dissection as prophylactic and I think this certainly would be true if we were talking of carcinoma of the anus or of the vulva. Because of the peculiarities of this tumor, as described by Drs. Pack, Treevers, Conway, these patients do better than other patients that have an epidermoid carcinoma with palpable nodes. I would have been happier if the metastases had been confined to the superficial femoral nodes. Unfortunately, there was a very large block of iliac nodes which were also positive for cancer.

We have talked of therapeutic lymph node dissection in contrast with prophylactic lymph node

dissection, and possibly this is confusing. Lymph node dissection is not an ancient procedure. Basset, in 1912, thought that cancer of the clitoris did better with lymph node dissection. He designed the procedure so that superficial lymph nodes could be excised for the safety of the patient. Taussig modified this a few years later and his operation included an attempt at removal of the lymph nodes along the external iliac artery. By and large, the deep lymph nodes of the external iliac artery can be considered medial, lateral and central. The medial group is often referred to as the obturator group of lymph nodes.

There are certain indications for a groin dissection that we should have clear. One should not perform palliative groin dissections if the primary lesion is not controlled. The older literature stated that epidermoid carcinoma in the groin, when treated with irradiation therapy, would inevitably fungate, rupture the femoral artery, and cause loss of the limb. Current radiation therapy, with high energy machines and deeper penetration is safe and can give as good palliation as a groin dissection. Groin dissection, as in this case, should be used when there is a reasonable chance for cure.

By and large, the commonest indications for groin dissection are malignant melanoma and epidermoid carcinoma of the genitalia or lower extremity. Another problem is that this is not an operation done commonly and is divided amongst three or four surgical specialties. In our center, about 20% of groin dissections are done for cancer of the penis by the urologists, approximately 35% by our gynecologists for carcinoma of the vulva and clitoris, with the remaining groin dissections done in the general surgical group for melanoma and carcinoma of the anus.

Therapeutic groin dissection is the resection of palpable lymph nodes which are thought to contain metastatic cancer. Marjolin's ulcer is a rare problem and the associated inflammation can lead to pelvic ilioinguinal lymphadenopathy. Generally, if one feels that the ilioinguinal lymph nodes are positive, one should perform a groin dissection.

The indication for therapeutic and prophylactic lymph node dissection has been an area of disagreement. The value of prophylactic groin dissections is still being evaluated in some areas. Prophylactic groin dissection is indicated for epidermoid cancers originating in the genitalia. Gynecologists feel that carcinomas of the vulva seem to do much better when the lymph nodes

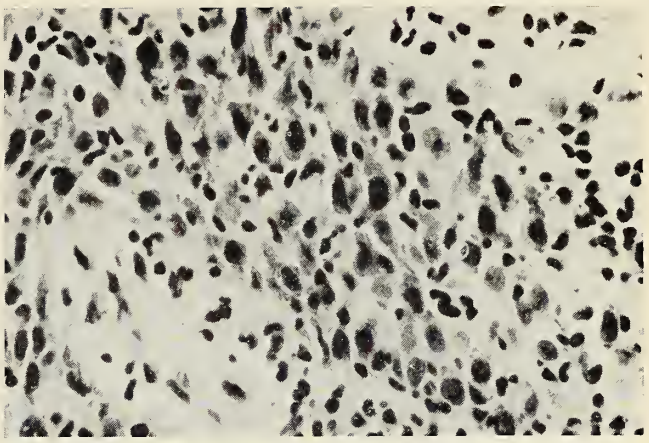


Fig. 4. Photomicrograph showing the features of squamous cell carcinoma.

are resected. The skin of the genitalia is very thin, and there are very large lymphatics immediately underneath the skin. In the median, raphe of the perineum of the lymphatics cross over freely. When cancer of the genitalia is present and one ilioinguinal area is positive, we have to assume that the opposite ilioinguinal area is also positive.

Groin dissection is not a popular operation because the patient often requires hospital care for weeks. From Ellis Fischel Hospital, one of the best statistical analyses I've seen of groin dissection was published in 1967. They concluded that the oblique or hernia-type incision is superior to other incisions. With the old vertical incision, almost all of our patients were in the hospital for more than two months after resection. The question comes up, however, in doing this operation, are we doing as good a cancer procedure as is accomplished through the other incisions with a higher morbidity? Interestingly, Spratt quotes extensively in justifying this incision the basic work of Daseler, Anson and Reimann from Northwestern. They dissected 450 cadavers and described a parallelogram with a 12 cm. upper margin paralleling the inguinal ligament, a lateral margin of 20 cm. formed by dropping a perpendicular from the anterior superior spine inferiorly by a transverse line 11 cm. in length, and medially by a perpendicular line dropped just medially to the pubic tubercle. This quadrilateral space contains the desired lymph nodes to be resected.

All soft tissues should be sutured, ligated, not for blood vessels but for lymphatics which are not visible. The majority morbidity in the wound of an ilioinguinal lymph node dissection is subsequent to the lymphocele or accumulation of

lymph in the groin which lifts the flap and breaks down the wound. After Rovier's original description and classification of the ilioinguinal lymph nodes, Dr. Anson carried on with the same schema in his basic work and found that the lymph nodes do cluster within this parallelogram that we have outlined.

This technique, which makes the procedure much easier both for the patient and for the surgeon, does result in lymphedema. These patients do have to be off their feet for an hour or two a day, and should be committed to support hose the rest of their days. If they will just take these precautions, I believe the operation has few other limitations to the patient.

Dr. John Bell: This patient has had a long history at Passavant Hospital. In 1945, Dr. Walter Carroll applied partial thickness skin grafts to the burns on his left leg. At that time, the open wounds had been present for more than 20 years. With a burn of such long duration, the fibrosis is too extensive to permit complete surgical excision. In such a case, one has to be satisfied with attaining wound closure by grafting on a bed which is not ideal.

When I first saw this man in 1968, he had had a skin carcinoma excised from the leg, and the presenting problem was one of attaining wound closure over exposed tibia. Instead of subjecting him to a pedicle flap, the cortex of the tibia was removed. When healthy granulation tissue appeared, a partial thickness skin graft was applied. This area remained closed, but other ulcerations occurred subsequently in the old burn of the leg.

Dr. Peter McKinney: When a pathological specimen is reported as pseudoepitheliomatous hyperplasia, it has been the experience of many surgeons that, in time, this type of wound will develop squamous cell carcinoma if it has not done so already. This diagnosis should make the alert surgeon wary.

In addition, this patient emphasizes the necessity of closing all wounds. There are fewer indications for having a wound open today than when this patient was injured some 50 years ago. The sequella of Marjolin's ulceration is purely from lack of wound closure after the original insult.

Dr. James Stack: In chronic osteomyelitis, when squamous cell carcinoma develops in draining sinuses, the first sign of carcinoma may be enlargement of an inguinal node.

Dr. Beal: Dr. Kent, do we have any information concerning the pathogenesis of carcinoma in burn wounds or chronic draining sinuses?

Dr. Geoffrey Kent: Why some conditions favor the development of carcinoma, and why cancer develops more readily in a scar resulting from a burn than from another type of injury is difficult to say. Of the possible underlying factors, one might mention continuing cellular breakdown and repair, an unfavorable nutritional environment, and impaired immune mechanisms. It should be pointed out that pseudoepitheliomatous hyperplasia does not denote premalignancy; rather, it implies a benign hyperplastic state with faint histologic resemblance to malignancy. In burn scars, the transition from this state to frank malignancy is indeed rare. Otherwise, the sequence of changes observed in burn scars is the same as in spontaneously developing and experimentally induced neoplasms of the skin. In all these, carcinoma seems to evolve through successive stages of hyperplasia and hyperkeratosis, papillomatosis, carcinoma *in situ* and infiltrating carcinoma. ◄

Reference

Spratt, J. S., Jr., Shieber, W. and Dillard, B.M.: Anatomy and Surgical Technique of Groin Dissection. St. Louis, C.V. Mosby Co., 1965.

Keeping business informed

"Knowledge of a problem is, of course, essential to its solution. But in our information-flooded world, the mere availability of knowledge is often not enough. For action to occur, the requisite knowledge must be delivered to the right place, at the right time. Seeing that the business community stays well informed is a prime mission of the National Chamber federation." —Arch N. Booth, executive vice president, Chamber of Commerce of the United States.

By Isa Sejdinaj, M.D., James McNeil, M.D., Richard C. Powers, M.D./Elgin

Appendico-Enteric fistula

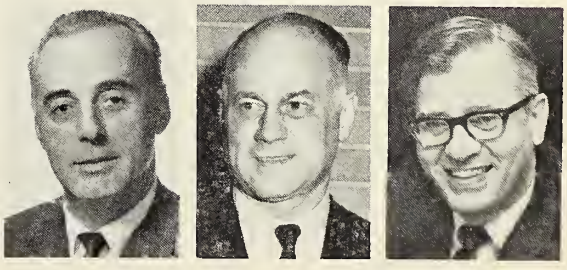
WHEN RENDERING SURGICAL TREATMENT upon a patient with cholelithiasis an incidental finding was a fistula existing between the tip of the appendix and the ileum which was also treated. A further incidental finding was the presence of a Meckel's diverticulum, and this combination of surgical diseases prompted an interest in a review of the surgical literature. As it developed, the presence of a fistula between the appendix and an intra-abdominal organ is an uncommon finding and is worthy of reporting as a case report.

Kjellman[1] provided an extensive review of the literature relating to appendiceal fistulae in 1957. He excluded all fistulae developing following appendectomy. Kjellman summarized the previous reports of eight patients with fistulae between the appendix and the bowel and later reported three more private patients. Forbes and Rose[2] summarized a number of published cases of appendico-vesical fistulae and found that these were a few over 50 in number. Walker, Rhame, and Smith,[3] added two more cases of fistula to the bowel. Pairolero, Judd, and Hodgson,[4] added a case report in 1969, of a patient with a spontaneous fistula from the appendix into the sigmoid colon.

ISA SEJDINAJ, M.D., (left) is attending surgeon in vascular surgery at Sherman and St. Joseph Hospitals in Elgin. He is a graduate of the University of Graz, Austria.

JAMES McNEIL, M.D., (center) is a general practitioner with a special interest in internal medicine. Dr. McNeil received his M.D. degree from Northwestern University Medical School and is a former clinical associate professor of the Department of Medicine, University of Illinois.

RICHARD C. POWERS, M.D., (right) is attending surgeon in vascular surgery at Sherman and St. Joseph Hospitals in Elgin. He is a graduate of the Northwestern University Medical School.



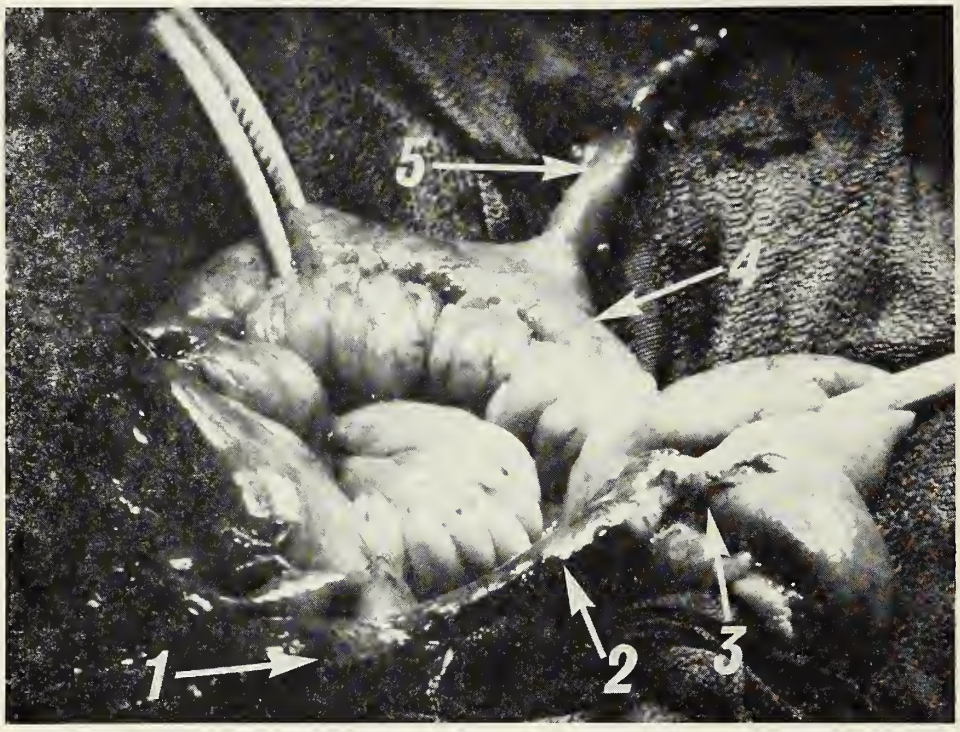


Fig. 1

Case Report:

A 57-year-old white male was hospitalized in Sherman Hospital, in Elgin, January 30, with right upper quadrant pain. This was acute in nature, radiating straight through to the back, was in association with repetitive vomiting, and terminated in hospitalization because of the unrelenting nature of the pain. The patient had had no previous gastrointestinal workups and there was no past history of previous abdominal surgery or of previous abdominal symptoms.

On physical examination, the patient demonstrated no icterus, but was febrile, 100.2°F. He was dehydrated but not toxic. Physical examination otherwise was not unusual except for the presence of marked right upper quadrant tenderness, with a suggestion of a mass. The white count was moderately elevated. The serum Amylase was normal. Plain films of the abdomen were not remarkable. Subsequent complete biliary tract and gastrointestinal studies were carried out, confirming the presence of a non-visualizing gallbladder, which was consistent with the clinical impression of hydrops of the gallbladder.

Surgery was carried out on February 8. The patient was confirmed to have an acute cholecystitis, with hydrops. In addition to this the patient had a classical Meckel's diverticulum in the usual position. The Meckel's diverticulum is labeled as #5 in Figure 1. The most unusual finding was the existence of a fistula (labeled #2) involving the appendix and terminating in the ileum (labeled #3) having its origin from the usual position of the cecum (labeled #1). The gallbladder was removed, and then the Meckel's diverticulum was resected. Figure 2 shows the surgical pathology involving the fistula from the tip of the appendix into the small bowel. The fistulous tract (#6) was lined with epithelium and found to communicate directly into the ileum (#7). Appendectomy was carried out, and the tract into the ileum was closed. The patient's post-operative course was uneventful, and he was discharged on the eleventh post-operative day. The microscopic pathologic findings were consistent with acute gangrenous cholecystitis, Meckel's diverticulum, and fistula from the appendix into the small bowel.

Comment

This fistula was incidental and non-symptomatic. On reviewing the patient's history, there was no episode which the patient could recall which would be suggestive of a previous episode of acute appendicitis, with perforation. There were no adjacent adhesive bands and no adjacent process suggesting primary inflammatory process involving other structures. The gross characteristics of the specimen suggested the possibility that this was a congenital type of fistula rather than one resulting from inflammatory process, but we are unable to find any other precedent for this in the literature and it

does not fit the known embryologic pattern. The existence of the Meckel's diverticulum was simply an added factor.

Summary

Occurrence of the unusual finding of an appendico-enteric fistula in the course of a private surgical practice prompted a review of the surgical literature. A paucity of reported cases was confirmed, so this patient is reported for its addition to the surgical accumulated literature as a case report. Appropriate commentary is made. ◄

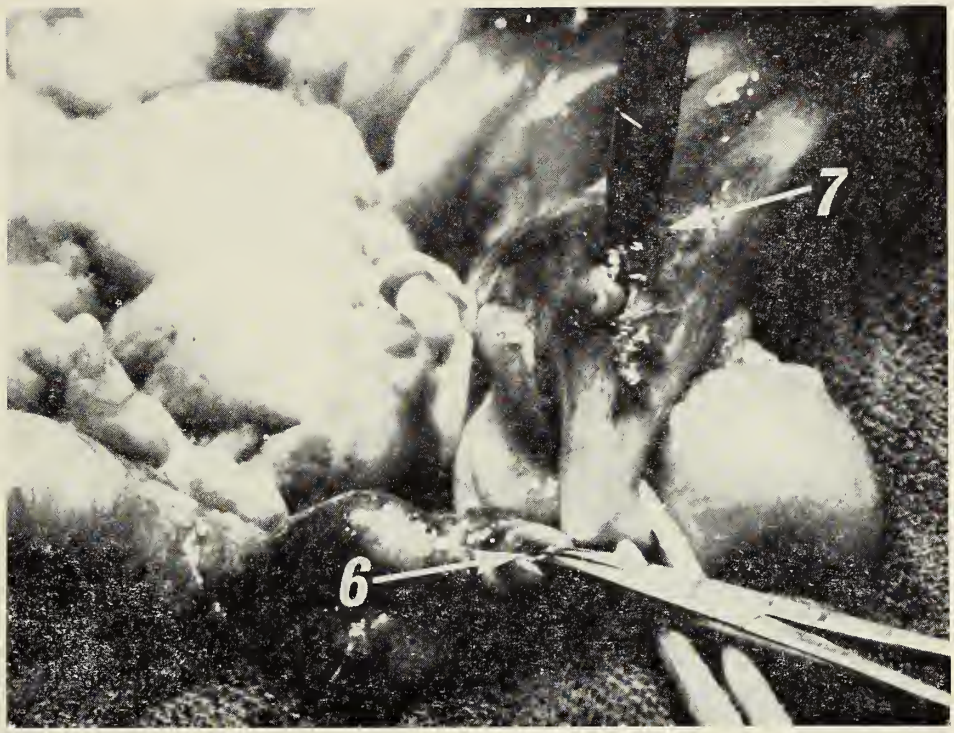


Fig. 2

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3. Walker, L.G., Rhame, D.W., and Smith, R.B.: "Enteric and Cutaneous Appendiceal Fistulae," *Arch. Surg.*, 99:585, 1969.
4. Pairolero, P.C., Judd, E.S., and Hodgson, J.R.: "Appendicoenterosigmoid fistula," *Surg.*, 66:695, 1969.

Cirrhosis and alcoholic hepatitis link-up

The development of cirrhosis during the healing of alcoholic hepatitis has been shown in this study. Cirrhosis was detected as early as five weeks after an initial biopsy in which no cirrhosis was noted. Repeat biopsies three to six months later have uniformly shown clear evidence of Laennec's cirrhosis; however, another group of patients with alcoholic hepatitis was shown to heal without development of cirrhosis. The histological features of necrosis and acute inflammation on initial biopsy were less marked in this group, although the number of patients is too small to determine which features are of most prognostic significance. Further studies correlating early histological changes with ultimate development of cirrhosis will be of interest. (Richard A. Helman et al.: Alcoholic Hepatitis (Natural History and Evaluation of Prednisolone Therapy). **Annuals of Internal Medicine** 74:3 (March, 1971), pages 311-321.)

By Wayne F. Spenader, M.D. and Barbara V. Schwamberger, R.N./Amboy

The treatment of acute alcoholism in a small rural hospital

ALCOHOLISM has been called by Dr. Roger Egberg, assistant secretary for Health and Scientific Affairs, the number one public health problem in the United States. This disease crosses all economic and social barriers. It is a rural, as well as an urban problem. Alcohol is easier to obtain than food in rural northern Illinois.

Alcoholism is looked upon as a disease by most law courts. Law enforcement officers are bringing alcoholics to the hospital instead of the jail. Hospitals will be confronted by increasing numbers of alcoholics asking admission and treatment.

Our treatment requires few drugs, and no special equipment and personnel. It is administered by our regular staff, in addition to their other duties. We have used this treatment with uniformly good results.

Treatment Plan

Diazepam* is the only drug used in our treatmet of the acute alcoholic. This drug has some unique advantages. In our opinion, it does not increase the central nervous system effects of alcohol; it effectively controls agitation, belligerency, convulsions; and helps the shaking and tremulousness of acute alchoholism.[1] Since we have used diazepam only in our treatment schedule, we have had no use for restraints, and have had no cases of delirium tremors or convulsions develop in a patient under treatment. If the patient is convulsing when admitted, diazepam readily controls these convulsions.

Diazepam can be administered by intravenous, intramuscular, or oral routes, and the dosage is the same no matter how administered. We have

(Continued on page 530)

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WAYNE F. SPENADER, M.D., is a family practitioner in Lee County, a member of the American Academy of General Practitioners and a Diplomate of the American Board of Family Practice. Dr. Spenader is a graduate of the University of Pennsylvania School of Medicine.

BARBARA V. SCHWAMBERGER, R.N., is administrator of the Amboy Public Hospital in Amboy, and a graduate of the Rockford Memorial Hospital School of Nursing.



what goes on

a guide to continuing education

November 19-20—University of Kentucky

"Psychiatry Put Into Practice"

Fee: $75 For information write: Frank R. Lemon, M.D., Associate Dean for Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506

University of Kentucky Medical School, Lexington, Ky.

November 20-21—American Society of Anesthesiologists

"Workshop on Acid Base Balance"

For information write: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, Illinois 60068

Fairmont Hotel, New Orleans, La.

November 28-December 1—American Society of Anesthesiologists

"Clinical Meeting"

For information write: American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, Illinois 60068

American Medical Association, New Orleans, La.

November 28—American Medical Association

"13th National Conference on the Medical Aspects of Sports"

Included will be forums and discussion sections relating to drugs, in sports, protection of the lower extremities, electrolyte and thermal balance, innovations in sports medicine through state medical societies, team-physician relationships, crucial health perspectives, and a medical focus on athletics. Conference is open to all key non-members and interested physicians. For information write: Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn St., Chicago, Illinois 60610

November 28—American College of Nutrition

"12th Annual Session"

Clinical reports on the role of nutrition in the American manned space flights, on diabetes, on anemias and on gastrointestinal disorders will highlight the scientific program. A symposium on hyperlipidemia and atherosclerosis will also be held. For information write: A. Leonard Luhby, M.D., Secretary-Treasurer; 1240 Fifth Avenue; Room 215; New York, N.Y. 10029

Royal Senasta Hotel, New Orleans, La.

December 3-5—American College of Chest Physicians

"Chest Trauma—Recent Advances in Emergency Management"

For information write: American College of Chest Physicians, 112 East Chestnut St., Chicago, Illinois 60611

University-Bellevue Hospital Center, New York, N.Y.

December 4-9—American Academy of Dermatology

"30th Annual Meeting"

Among major symposia will be those covering such clinical problems in skin disease as dermatologic genetics, cutaneous tumors, pediatric skin diseases, skin allergy, psoriasis, acne, venereal diseases, new medications and therapeutic techniques. For information write: Frederick F. J. Kingery, M.D., Secretary-Treasurer, 2250 Northwest Flanders St., Portland, Ore. 97210

Palmer House, Chicago, Illinois

December 6-9—Louisiana State University

"8th Annual Postgraduate Course on Pulmonary Function in Health and Disease"

Tuition for physicians is $125; members of the American Thoracic Society $100; limited number of nurses and inhalation therapists $75. The course will cover lung volumes and spirometry, mechanics of breathing and ventilatory distribution, pulmonary gas exchange from the aspects of both ventilation perfusion relationships and pulmonary diffusing capacity. Registration information write: Robert Goldstein, J.D., Associate, Program of the Louisiana Thoracic Society, Suite 1504; 333 Charles Ave., New Orleans, La. 70130, or call (504) 523-1311

Louisiana State University School of Medicine, New Orleans, La.

December 7-9—American Academy of Orthopaedic Surgeons

"8th Annual Sumner L. Koch Hand Surgical Seminar"

This course is for orthopaedic surgeons, plastic surgeons, industrial surgeons and general practitioners. Directing the three-day course of lectures and panel discussions will be Dr. John A. Boswick, Jr., chairman, Dept. of Hand Surgery, Cook County Hospital, and professor of surgery, University of Illinois. For application forms and information write: John A. Boswick, Jr., M.D., 1825 West Harrison Street, Chicago, Ill. 60602, or the American Academy of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, Ill. 60611

Drake Hotel, Chicago, Illinois

December 7-9—University of Texas Graduate School of Biomedical Sciences

"Heart and Sound Murmurs"

For information write: The Office of the Dean, The University of Texas Graduate School of Biomedical Sciences at Houston, Division of Continuing Education, P. O. Box 20367, Houston, Texas 77025

University of Texas, Houston, Texas

December 8—University of Illinois

"Medicine and Youth"

This program will include lectures on "Some Developmental Issues on Contemporary Adolescents;" "Youth and Drugs-Management of the Bad Trip;" "The Young Woman as a Gynecologic Patient;" "Psychiatric Treatment of College Age Individuals;" and Family Therapy and the Adolescent." There will be questions and discussion. For information write: University of Illinois, Frontiers of Medicine, The University of Chicago, BH Box 451, 950 E. 59th St., Chicago, Ill. 60637, or call (312) 947-5110

December 9-10—Louisiana Thoracic Society

"Pediatric Pulmonary Function and Disease"

The two-day post-graduate course will include: (1) a "wet hands" approach to certain aspects of pulmonary function testing of children and to chest roentgenographic interpretation; and (2) a synthesis of roentgen "structure" and respiratory physiology by means of carefully selected case presentations in which each method complements the other.
Course tuition is $75. Additional information may be acquired by contacting: Miss Marlys Anderson, Louisiana Thoracic Society, Suite 1504, 333 St. Charles St., New Orleans, La. 70130

Louisiana State University School of Medicine Aud., New Orleans, La.

December 17-18—University of Kentucky

"Annual Family Medicine Review"

Fee $50. For information write: Frank R. Lemon, M.D., Associate Dean for Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40506

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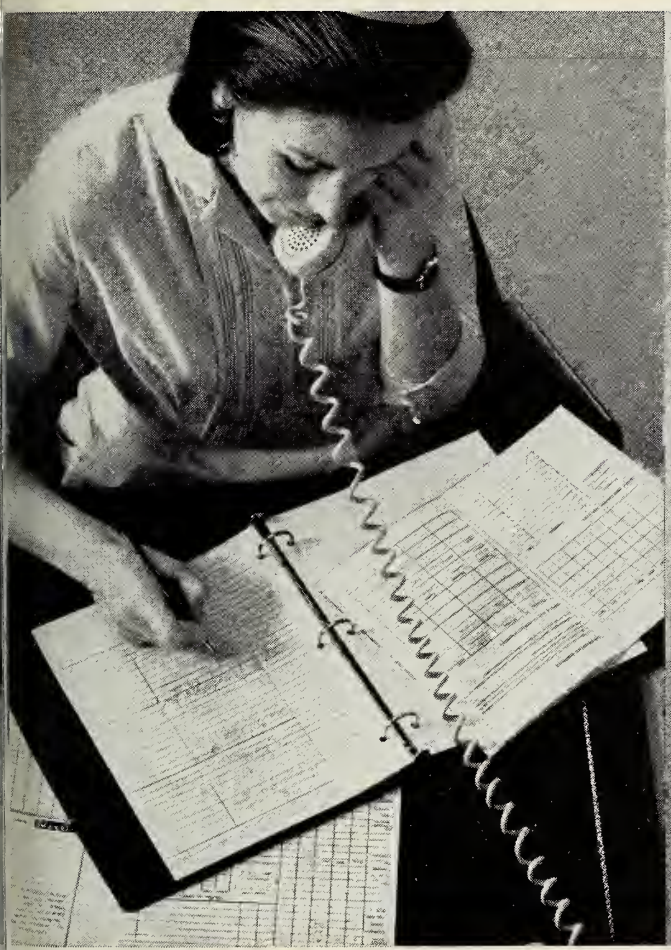
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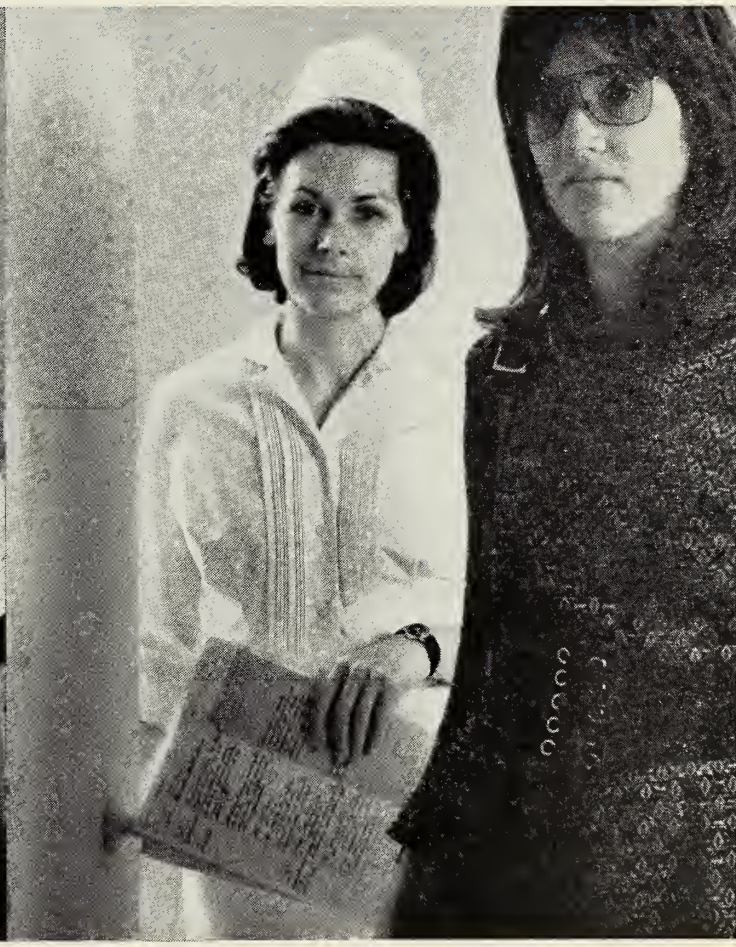
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new pharmaceutical specialties

by paul dehaen

Single Chemicals—Drugs not previously known, including new salts.
Duplicate Single Products—Drugs marketed by more than one manufacturer.
Combination Products—Drugs consisting of two or more active ingredients.
New Dosage Forms—Of a previously introduced product.
The following new drugs have been marketed:

New Single Chemicals

CAPASTAT SULFATE Antitubercular ℞
Manufacturer: Lilly
Nonproprietary name: Capreomycin sulfate
Indications: Used concomitantly with other appropriate antituberculous agents
Contraindication: Renal insufficiency or hearing impairment; not for pediatric use
Dosage: 1 gm. daily
Supplied: Ampules, 5 cc., 1 gm.

CORTROSYN Hormone-ACTH ℞
Manufacturer: Organon
Nonproprietary name: Cosyntropin
Indications: Diagnostic aid in determining adenocortical insufficiency
Contraindications: Previous history of adverse reaction
Dosage: 0.25 to 0.75 mg. i.v. or i.m.
Supplied: Vials, 0.25 mg.

TROBICIN Antibiotic ℞
Manufacturer: Upjohn
Nonproprietary name: Spectinomycin dihydrochloride pentahydrate
Indications: Acute gonorrhea infection
Contraindications: Should not be given in known hypersensitivity
Dosage: Male: 2 gm. (one injection)
Female: 4 gm. (two injections)
Supplied: Vials, 2 gm. and 1 gm.

Duplicate Single Products

ALLERBID Antihistamine ℞
Manufacturer: Amfre-Grant
Nonproprietary name: Chlorpheniramine maleate
Indications: Allergic reactions
Contraindications: Known idiosyncrasy to the drug
Dosage: Adults: 1 capsule every 8 hrs.
Children: (6 to 12 yrs.), 1 capsule daily
Supplied: Capsules, 8 mg.

GANPHEN INJECTION Antihistamine ℞
Manufacturer: Tugag
Composition: Each cc. contains:
Promethazine HCl 50 mg.
Indications: If use of oral form is impractical; allergic conditions amenable to antihistamine therapy
Contraindications: Idiosyncrasy to promethazine hydrochloride
Dosage: Follow instructions of package insert
Supplied: Vials, multiple dose 10 cc.

HypRho-D Biological ℞
Manufacturer: Cutter
Composition: Immune Globulin (Human)
Indications: Administered to Rh-negative mothers within 72 hrs. after birth of an Rh-positive child or after miscarriage of an Rh-positive fetus
Contraindications: See package insert
Dosage: Entire contents of syringe intramuscularly
Supplied: Syringe disposable, one dose
Vial, dilution 1:1000 (for cross match test)

N-TOIN Antiinfective Urinary ℞
Manufacturer: Upjohn
Nonproprietary name: Nitrofuratoin
Indications: Pyelonephritis, pyelitis, cystitis
Contraindications: Anuria, oliguria or extensive impairment of renal function; pregnancy or infants under three months of age
Dosage: Adults: 50-100 mg. four times a day
Children: 5-7 mg. per kilogram of body weight per 24 hrs.
Supplied: Tablets, 50 mg., 100 mg.

SK-BAMATE Ataraxic ℞
Manufacturer: Smith Kline French
Nonproprietary name: Meprobamate
Supplied: Tablets, 200 mg., 400 mg.

SK-PETN Vasodilator - Coronary ℞

Manufacturer: Smith Kline French
Nonproprietary name: Pentaerythritol tetranitrate
Supplied: Tablets, 10 mg., 20 mg.

SK-SOXAZOLE Sulfonamide ℞
Manufacturer: Smith Kline French
Nonproprietary name: Sulfisoxazole
Supplied: Tablets, 500 mg.

Combination Products

DITATE Hormone ℞
Manufacturer: Savage
Composition: Each cc. contains:

	Ditate	Ditate-DS
Testosterone enanthate	90 mg.	180 mg.
Estradiol valerate	4 mg.	8 mg.

Indications: Post-menopausal and senile osteoporosis
Contraindications: Mammary or genital carcinoma or familial history; pre-existing heart disease
Dosage: 1 cc., every three or four hours
Supplied: Vials, Ditate-multidose 10 cc.
Ditate-DS-single dose 2 cc.

GIOLATE Antacid ℞
Manufacturer: Amfre-Grant
Composition: Each tablet contains:

Dihydroxyaluminum aminoacetate	0.5	gm.
Phenobarbital	8.1	mg.
Hyoscyamine sulfate	0.0519	mg.
Atropine sulfate	0.0097	mg.
Hyoscine hydrobromide	0.0033	mg.

Indications: Gastric and duodenal ulcer, hyperchlorhydria, pyrosis, gastritis, enteritis, colitis, and G.I. spasm
Contraindications: Glaucoma, advanced renal or hepatic disease or hypersensitivity to any of its ingredients
Dosage: One or two after meals and before retiring
Supplied: Tablets

New Dosage Form

NEBS Analgesic o-t-c
Manufacturer: Eaton
Nonproprietary name: Acetaminophen
Indications: Headaches, teething, muscular aches, "flu"
Contraindications: None listed
Supplied: Liquid, 5 cc.=125 mg.

FDA news

Drug quality control: Problem with Digoxin

In a recent monitoring program on digoxin tablets, the FDA's National Center on Drug Analysis reported that 47% of the batches investigated did not comply with the requirements of the USP monograph, chiefly because of failure in the content uniformity test. In one of the worst examples, NCDA found digoxin tablets containing twice the declared quantity of active ingredients. The same bottle contained tablets with 60-70% of the declared quantity. The manufacturers agreed to recall the violative lots. A follow-up program on digoxin tablets is underway, and the Bureau of Drugs is monitoring production to assure content uniformity of individual tablets.

On the basis of the digoxin findings, and other studies of diverse pharmaceutical products containing high potency drug substances in relatively low concentrations, FDA has concluded that direct tests for content uniformity are essential. Testing of bulk formulation material has proved unreliable as a measure of uniform content in individual dosage units. When such procedure is used, it is still possible for many of the tablets punched from the formulation mass to fall far outside permissible potency limits.

The significance of this finding to the prescribing physician is obvious: If a previously well-digitalized patient displays signs of under or over-digitalization, the problem may be with the drug rather than with the patient. Certainly, this possibility should be borne in mind when such signs appear.

The Food and Drug Administration is working to eliminate the problem of variable potency and its Bureau of Drugs has undertaken extensive investigations. In establishing the National Center for Drug Analysis, the Bureau has significantly expanded its capacity for gauging the quality of drug control in general. As a result of the Center's marked success in developing automated methods of analysis and applying them to individual units of dosage forms, NCDA is now able to focus attention on problem situations involving deviations from content uniformity requirements.

(Continued on next page)

[1]*Adapted from a paper delivered at the Mid-Year Meeting of the National Association of Pharmaceutical Manufacturers, February 14, 1971, at Washington, D.C., by Daniel Banes, Ph.D., Director, Office of Pharmaceutical Research and Testing, Bureau of Drugs, FDA.*

Methotrexate: Its use in psoriasis

Psoriasis has for ages challenged the physician's therapeutic resources. A recurrent disease, it is characterized by exacerbations and remissions which sometimes are difficult to control with conventional therapies.

Some cases of psoriasis which are severe, disabling and resistant to conventional therapy have been effectively treated with the anti-metabolite drug, Methotrexate.

The Food and Drug Administration and the FDA's Advisory Committee on Dermatology have reviewed a series of clinical investigations and based on the recommendations of the Advisory Committee, the FDA has concluded that Methotrexate is safe and effective for the treatment of certain cases of psoriasis.

The FDA-approved directions for use in these cases will soon be available from the manufacturer Lederle Labs, and should be reviewed carefully before the drug is used in the treatment of psoriasis.

The labeling of Methotrexate restricts its use in psoriasis to severe, disabling, proven cases recalcitrant to more conservative treatment and makes the following recommendations:

- screening of patients by all appropriate parameters to exclude administration of Methotrexate to pregnant women and to patients with pre-existing renal, hepatic, or hematopoietic disease;
- screening of patients to disclose any pre-existing infections that might be activated by use of an immunosuppressive agent; and
- ensuring the availability of facilities for close medical and laboratory supervision of patients receiving the drug for psoriasis. Supervision should include CBC, urinalysis, serum creatinine, liver function studies, and liver biopsy, if indicated.

Methotrexate should be used only by physicians who are thoroughly familiar with the severe adverse effects, including deaths, associated with the use of anti-metabolite drugs. Deaths that have occurred during Methotrexate treatment for psoriasis usually have been preceded by signs and symptoms of bone marrow aplasia (e.g., hemorrhagic enteritis). Patients should fully be informed of the risks involved and closely monitored. The drug should be discontinued promptly in the event of developing renal or hepatic toxicity.

Methotrexate has been marketed for 18 years as an important representative of anti-neoplastic chemotherapy. Use of an anti-neoplastic drug for treatment of an incurable dermatologic condition must be carefully weighed by the physician after consideration of the risks and benefit to his patient.

Methotrexate should be used only when other, less toxic drugs have failed to bring improvement to patients disabled with severe psoriasis. Please note that the drug is to be dispensed to patients *by physicians only.*

AMA-ERF contributions

The following individuals have made contributions of $100 or more in 1971 to the AMA-ERF, as of August, 1971.

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socio-economic news

a service of the division of health care delivery

By Joseph J. Lotharius

Illinois FMC signs HASP contract With State

A Hospital Admission and Surveillance Program (HASP) that could save the state's faltering Medicaid program about $12 million will be implemented by the Illinois Foundation for Medical Care. The HASP contract was approved by IFMC Board members and signed by the Foundation president, and the state's directors of the Department of Public Aid and the Department of Public Health. Under HASP, physicians will certify all hospital admissions for Medicaid patients using the Professional Activities Study (PAS) as the base point for determining lengths of stay. HASP physicians would also be responsible for monitoring the activities of hospital utilization review committees in accordance with federal standards. The HASP contract calls for implementing the first phase of the program—establishing state and regional HASP committees—by December 1, 1971. By January 1, 1972, an admissions program must be functioning in those hospitals with more than 1,000 Medicaid hospital days in September, 1971, and having residency training programs in medicine and surgery.

Now IFMC is "For real"

More than 1,500 ISMS members representing every county medical society in the state have become members of the Illinois Foundation for Medical Care. Approximate total membership applications received from the larger county societies include: Chicago Medical Society, 600; Champaign, 60; DuPage, 50; Sangamon, 40; Peoria, 40; Winnebago, 35; Will-Grundy, 25; St. Clair, 25; Kankakee, 20; and Lake 20. IFMC Board members urged their colleagues who have not yet returned membership applications to do so. A strong state Foundation is vital in future negotiations for statewide contracts, both private and governmental.

Malpractice Suit—NO! Arbitration—YES!

Arbitration as an alternative to malpractice suits appears to be working in California. Dr. Aaron J. Fink, a Mountain View urologist, asks his patients to sign an arbitration agreement whereby any controversies between physician and patient are submitted to arbitration. Thus far, only 10 patients out of 700 have refused to sign the agreement. The

Ross-Loos Medical Group in Los Angeles has made arbitration part of its prepaid health care plan.* In both examples, the arbitration procedure is administered by the American Arbitration Association.* (From *Medical Tribune*—August 18, 1971, and *JAMA*—Vol. 211, No. 2)

8% of Illinois' Residents on welfare

Eight per cent of Illinois' population is on public welfare according to the Illinois Department of Public Aid. This figure represents an increase of two per cent over 1970. IDPA says 865,000 persons are on public welfare now compared with 685,000 just 18 months ago. This substantial increase in the caseload has thrown the state's welfare program into a fiscal crisis.

So you've been invited to give a speech . . .

DON'T accept any speaking engagement until you've given the matter careful thought.

FIND OUT FIRST who the other speakers will be, particularly if you're on a panel; where the meeting will be held; size and kind of audience; the length of the talk desired; whether there will be a question and answer period.

With these facts, you will be able to determine whether you can give a talk which will be suitable to the audience's interest. And whether you are qualified. Do you still think you can give a good account of yourself?

Then—and only then—will you know whether to say yes or no to the invitation.

Whether you are talking to an audience of 5 or 5,000, the qualities that spell success are the same and they can be achieved through planning and practice.

As for the length of your talk, it's well to heed the clerical axiom, **"No souls are saved after twenty minutes."** Nor should you employ the tactics of old time orators who kept the audience awake only by the loudness of their voices. Neither loudness nor length is any test of excellence in a speech.

Fight the temptation to begin talking the second the program chairman introduces you. First, pause a few seconds after being introduced. It's best to skip a long introduction and to plunge into your subject. Many experienced speakers begin with a knowledgeable compliment to the audience, organization and place. If you're pleased to be with the group, it won't hurt to say so. Above all, don't begin with an unrelated joke.

Many a well-prepared speech has failed for lack of rehearsal. If you run through a speech several times you usually speak from cards or notes, to remind you of main points. And you won't run overtime. But rehearsal isn't just practice—it has to be intelligent practice. Intelligent, because the psychologists tell us practice doesn't necessarily make perfect, it only makes permanent.

Being easy in front of an audience comes from being well prepared and well rehearsed, and knowing you are both. Your desire to communicate should be strong enough to cause nervousness, but never paralyzing fear. In fact, nervousness can be down right helpful if it drives you to the important task of preparation.

While presenting your speech, be psychologically ready for anything. If you're a member of a panel, you may have to cut material because a preceding speaker deals with it in an ad lib.

An awkward finish has marred many an excellent speech. After uttering the last word, nod to your audience, smile, turn, and walk to your chair. It's that simple. And remember, it's not an act of discourtesy NOT to thank your audience. In fact, a "thank you" weakens your talk by seeming to apologize to an audience that should appreciate the message you've given them.



editorials

Control of hypertension: An unmet challenge*

It is more than disquieting that a 50-year-old man in 1970 has a future life expectancy only one-tenth of a year greater than his counterpart had in 1900, 70 years ago.[1] Clearly the great strides of modern medicine have been only faltering foot steps against the chief cause of death in the United States, cardiovascular disease. Among types of cardiovascular disease, hypertension stands out because it can be controlled; yet today its control constitutes a major unmet challenge to the medical profession.

Hypertension is, first and foremost, a very common condition, affecting over 20,000,000 Americans.[2] It is even more prevalent and has a higher mortality and morbidity in Negroes.[3] Aside from its relationship to hypertensive heart disease, heart failure, stroke and renal failure, hypertension is closely related to the acceleration of the artherosclerotic process. Here it acts in conjunction with the other risk factors which have been identified—hypercholesterolemia, cigarette smoking, and hyperglycemia—to hasten the development of a condition, the delay of which might give the only hope for significantly prolonging life in this country.

Recent studies[4] have shown that even mild elevations of blood pressure are far from "benign" in terms of morbidity and premature mortality, yet, as will be seen, the public and the medical profession have adopted a hands-off attitude of non-intervention, lulled into inaction by the lack of immediate symptoms and the prolonged course before target organs of the disease are irreversibly damaged.

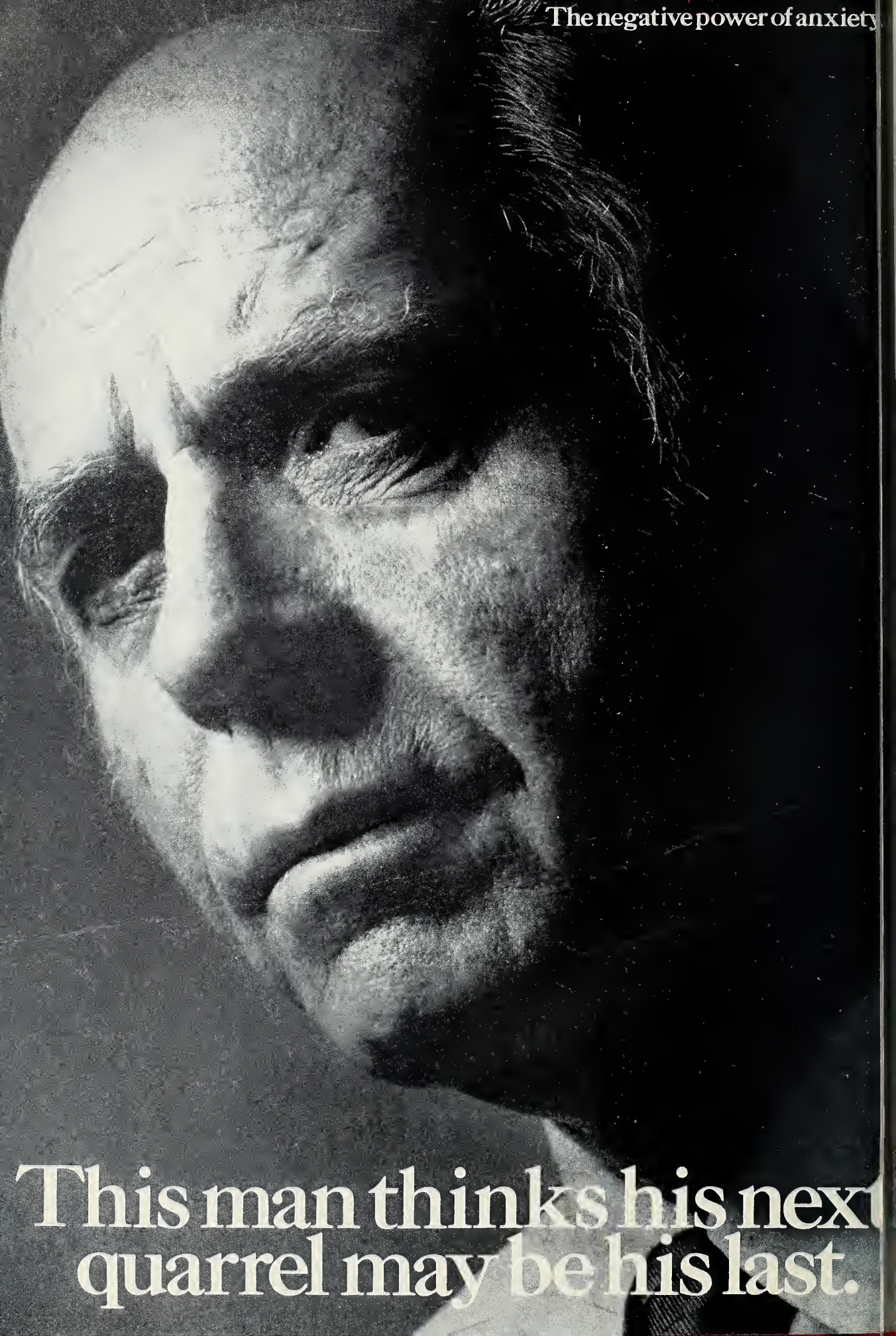
Control of hypertension can reassurably be expected in 90% of cases with drugs presently available.[5] The crucial evidence that such treatment makes a significant impact on the morbidity and mortality of the disease has long been available empirically for the severe forms of accelerated and malignant hypertension and no physician would consider withholding treatment from these patients.

Two recent reports of a cooperative Veterans Administration study[6,7] now demonstrate that the untreated course of milder degrees of hypertension is a great deal worse than the course under treatment which achieves long-term effective lowering of the blood pressure. For patients with initial diastolic blood pressures of 115 mm hg or greater, the study had to be terminated after 20 months because the control group of untreated hypertensives developed major cardiovascular complications far in excess of those in the treated group. For patients with initial diastolic pressures of 90-114 mm hg, a longer period of observation showed, by life table analysis, that the risk of a major cardiovascular complication was reduced from 55% to 18% by treatment. The proof that treatment is beneficial for the mildest degrees of hypertension is not yet conclusive and this problem is currently under investigation.[8] Meanwhile, all the evidence points to the conclusion that the benefits from the control of any persistent elevation of blood pressure far outweigh the risks of treatment or allowing the disease to go untreated.

If one grants the validity of these conclusions, what is the evidence that the challenge of the control of this major disease is unmet? At least two surveys[9,10] have looked at this question and have confirmed the impression that only a frac-

(Continued on page 529)

**This statement has been approved in context by the Ad Hoc Committee on Hypertension, Illinois Regional Medical Program.*



This man thinks his next quarrel may be his last.

A serious urinary tract infection...
Proteus vulgaris, confirmed by pure culture. Fortunately, the strain proves sensitive to carbenicillin and the patient is not allergic to penicillins. The choice is clear: Pyopen.

Unlike other antibiotics currently available for the treatment of Gram-negative sepsis, there are no reports of nephrotoxicity or ototoxicity with Pyopen therapy. Particularly valuable in urinary infections, because of its exceptionally high urine levels, its effectiveness against *Ps. aeruginosa* and *Proteus* species has been amply confirmed by clinical experience and microbiologic studies.

Pyopen is a product of Beecham, the company which pioneered most of today's semi-synthetic penicillins. Your Beecham-Massengill representative would like to give you proof of our dedication to the concept of Total Service.

THE TOTAL SERVICE CONCEPT:
Beecham-Massengill's dedication to the concept of total service is exemplified by the Pyopen Program — offering valuable teaching-learning materials and an added measure of personal attention: *Gram-Negative Sepsis*, a multimedia presentation by leading American medical authorities...*A Profile of Pseudomonas*, a monograph for the clinical microbiologist... *24-hour consultation service* in matters relating to carbenicillin (phone: 201-778-9000)... *emergency supply*, a novel plan for assuring the continual availability of Pyopen to hospitals specifying this brand of carbenicillin.

For additional information about the Beecham-Massengill Total Service Concept see our representative or write to us directly.

BEECHAM-MASSENGILL PHARMACEUTICALS
Div. of Beecham Inc.
Bristol, Tennessee 37620

PRESCRIBING INFORMATION **Indications:** Primarily for treatment of infections due to susceptible strains of *Pseudomonas aeruginosa*, *Proteus* species (particularly indole-positive strains), and certain *Escherichia coli*. Clinical effectiveness has been demonstrated in the following infections when due to these organisms: Urinary tract infections; severe systemic infections and septicemia; acute and chronic respiratory infections (while clinical improvement has been shown, bacteriologic cures cannot be expected in patients with chronic respiratory disease and cystic fibrosis); soft tissue infections. Although PYOPEN (disodium carbenicillin) is indicated primarily in Gram-negative infections, its activity against Gram-positive organisms should be kept in mind when both Gram-positive and Gram-negative organisms are isolated (see Actions). **Note:** During therapy, sensitivity testing should be repeated frequently to detect the possible emergence of resistant organisms. **Actions:** Organisms found to be susceptible *in vitro* include: Gram-Negative Organisms-*Ps. aeruginosa*, *Proteus mirabilis*, *Pr. morganii*, *Pr. rettgeri*, *Pr. vulgaris*, *E. coli*, *Enterobacter* species, *Salmonella* species, *Hemophilus influenzae*, and *Neisseria* species. Gram-Positive Organisms-*Staphylococcus aureus* (nonpenicillinase-producing), *Staph. albus*, *Diplococcus pneumoniae*, Beta-hemolytic streptococci, and *Streptococcus faecalis*. Some newly emerging pathogenic strains of *Herellea*, *Mima*, *Citrobacter*, and *Serratia* have also shown *in vitro* susceptibility. Not stable in the presence of penicillinase. *Klebsiella* species are resistant. Some strains of *Pseudomonas* have developed resistance fairly rapidly. **Contraindications:** Known penicillin allergy. **Warnings:** Serious and occasional fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, appropriate therapy should be instituted and discontinuance of disodium carbenicillin therapy considered, unless the infection is life threatening and only amenable to disodium carbenicillin therapy. The usual agents (antihistamines, pressor amines, and corticosteroids) should be readily available. **Usage in Pregnancy:** Safety for use in pregnancy has not been established. **Precautions:** As with any other potent agent, it is advisable to check periodically for organ-system dysfunction, including renal, hepatic, and hematopoietic systems, during prolonged therapy. Emergence of resistant organisms, such as *Klebsiella* species and *Serratia* species, which may cause superinfection, should be kept in mind. Each gram contains 4.7 mEq sodium; in patients where sodium restriction is necessary, such as cardiac patients, periodic electrolyte determinations and monitoring of cardiac status should be made. Observe patients with renal impairment for bleeding manifestations and adhere strictly to dosage recommendations. If bleeding manifestations appear, discontinue antibiotic and institute appropriate therapy. As with any penicillin preparation, the possibility of an allergic response, including anaphylaxis, may occur, particularly in a hypersensitive individual. **Administration:** Intramuscular injections should be made well within the body of a relatively large muscle (not into the lower and mid-third of the upper arm), and aspiration is necessary to help avoid inadvertent injection into a blood vessel. May be given by either intravenous injection or intravenous infusion. After reconstitution with Sterile Water for Injection unused portions should be discarded after 24 hours if stored at room temperature, or after 72 hours if refrigerated. **Adverse Reactions:** *Hypersensitivity Reactions*—Skin rashes, eosinophilia, pruritus, urticaria, drug fever, and anaphylactic reactions. *Gastrointestinal Disturbances*—Nausea. *Hemic and Lymphatic Systems*—Hemolytic anemia, thrombocytopenia, leukopenia, neutropenia, in uremic patients receiving high doses (24 gm/day), hemorrhagic manifestations associated with abnormalities of coagulation tests, such as clotting and prothrombin time. *Hepatic and Renal Studies*—SGOT and SGPT elevations have been observed, particularly in children. To date, no clinical manifestations of renal disorders have been demonstrated. *Central Nervous System*—Convulsions or neuromuscular irritability could occur with excessively high serum levels. *Local Reactions*—Pain at the site of injection, sometimes accompanied by induration. Vein Irritation and Thrombophlebitis—particularly when undiluted solution is injected directly into the vein. **How Supplied:** Available in 1 Gm. and 5 Gm. vials.
Before prescribing or administering, see package circular or PDR.



report

a service of the american association of medical assistants, illinois society

On becoming a certified medical assistant

By Lina Trotter/CMA, DeKalb County

Certification has been a goal of the Illinois Society since 1959 when the American Association of Medical Assistants' Special Committee was formed to study ways and means to establish professional standards for medical assistants. The following is a short history of the Certification Program.

The goals of the program were: (1) to help physicians identify those qualified as top-level office assistants; (2) to establish professional standards and goals for medical assistants; (3) to assist schools and colleges in developing training programs for medical assistants; (4) to prepare and administer an annual examination; and (5) to certify those who successfully completed the examination. The original committee ended its term in October, 1962 at which time they administered an examination in Detroit, Michigan to 22 medical assistants all of whom had good education and work experience background. The papers were analyzed and a detailed study outline and list of reference books prepared and furnished upon request for anyone who desired them. This list of reference books and study outline has been updated from time to time and is available upon request.

After the first test the Special Committee was replaced by a Certifying Board which now includes seven Certified Medical Assistants, one attorney, one educator, three physicians and the president and president-elect of the American Association of medical assistants as ex-officio members.

The examination itself is divided into two categories: Clinical and Administrative. The medical assistant may become certified in either or both categories. Every candidate must take the test for: (1) Medical terminology, anatomy and physiology; (2) Personal adjustment and human relations, medical ethics and etiquette; and (3) Medical law and economics. The clinical candidate, in addition to the above must take: (1) Examination room techniques, sterilization procedures and care of equipment and (2) Laboratory orientation. The administrative candidate, in addition to the three previously mentioned must take: (1) Office skills and procedures, accounting and collections and (2) Written and oral communications, records (both medical and non-medical).

A copy of the study outline and list of reference books are available as well as a brochure stating the qualifications for taking the examination. Why don't you send for one and see about helping your medical assistant to become certified?

Those medical assistants who have successfully passed the examination and are now Certified Medical Assistants are very proud of their status-and rightfully so. We have 613 in the United States and 26 from Illinois. For further information regarding certification please contact Mrs. Norma Domanic, 150 Ash Street, New Lennox 60451 or Mrs. Vivian Kraft, R.R. 2, Normal, 61761.

Dimetapp Extentabs®

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.
HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

Control of hypertension

(Continued from page 521)

tion of the hypertensives in the United States are receiving the benefits of easily available and effective treatment. In the Chicago survey[9] of 22,929 industrially employed workers, 4,625 had hypertension. Only eight percent of the white men were on treatment and had normal blood pressure as a result. Another 11% were taking medication but were still hypertensive. The balance, 81%, were undetected (65%) or untreated even though aware of being hypertensive (16%). Findings for white women and for Negroes were similar.

Thus, hypertension, remains a neglected disease, chiefly because its victims have not been identified, but also because they fail to adhere to long-term regimens when asymptomatic, and because the medical profession has yet to accept the need to adopt an aggressive attitude about its control. Summing up the evidence given here, the treatment of any persistent elevation of the blood pressure above the value of 140/90 mm hg is clearly justified. The management must be life-long for the disease rarely remits even after prolonged lowering.[11] The first goal of therapy should be prolonged lowering of the blood pressure to normal, or below the diastolic value of 90 mm hg. Unacceptable side affects are to be avoided in reaching this goal. Doctors must realize that an intense effort is needed to educate the patient about his disease in order to insure his faithful adherence to the regimen and regular follow-up in the office to maintain effective control.

Perhaps nowhere else in medicine is there such a dichotomy between what could be done to alter the course of a major disease, and what is being done at the present time. Hypertension is an *"unmet challenge."*

Morton C. Creditor, M.D.
James A. Schoenberger, M.D.

Reference

References for this article can be obtained by contacting: *IMJ,* 360 N. Michigan Ave., Chicago, Ill. 60601.

Treatment of alcoholism

(Continued from page 508)

encountered no local reactions to intravenous or intramuscular injections. Diazepam has negligible effects on cardiovascular or respiratory functions, and does not compete with alcohol for excretion by the liver.

The usual dosage of diazepam is 5-20 mgm, every four hours by any route, but we do not hesitate to use larger doses, up to 40 mgm every four hours, in severely agitated patients. Our usual method, in a severely agitated patient, is to administer 10 mgm intravenously on admission, and to give another 10 mgm intramuscularly at once. This regime is also used on the convulsing patient. We have used over 160 mgm in a 24-hour period on three patients, with no ill effects. As the patient improves, we change our route of administration to oral, and reduce the dosage as clinically indicated. Usually after 48-hours, we have been able to switch to oral doses.

If the patient is unconscious on admission, but subsequently becomes agitated, we do not hesitate to use full doses of diazepam as outlined. In our experience, the patient under diazepam sedation can be roused for feedings or nursing procedures.

Over 50% of our patients have been unable to tolerate oral feedings on admission. We routinely administer a balanced electrolyte solution, Polysal-M in 10% dextrose in water*, to these patients. We add an ampule of Solu-B forte** to each 1000 cc of the intravenous solution.

For a patient taking no oral fluids, we give 3000 cc of this intravenous solution daily, and reduce the amount as oral feedings increase. After 72-hours, most patients can discontinue the intravenous feedings. In all patients admitted with a diagnosis of acute alcoholism, we administer 1000 cc of intravenous fluid for two days regardless of oral intake.

We believe the glucose, electrolyte, and vitamin intravenous solution protects against hypoglycemic episodes, increases the patient's sense of well being, and hastens the detoxication of alcohol and its metabolites. The dosage of vitamins in the Solu-B forte ampule is pharmacological, rather than physiological. The dextrose solution also adds calories to the patient's intake.

**Cutter Laboratories, Inc. Berkeley, California 94710*
***Upjohn Co. Kalamazoo, Michigan 49001*

Oral feedings of relatively high calorie foods are started as soon as possible. It has been shown that a high calorie intake decreases the blood alcohol level.[2]

Ancillary Methods of Treatment

An indwelling catheter was used on four patients, usually for less than 48-hours. Antibiotics were administered to ten patients for a variety of infections including pneumonia, pyelonephritis, soft tissue abscesses, and pharyngitis. All patients have a liver profile which showed only minor abnormalities in our patients.

All personnel are encouraged to take a non-judgemental and non-moralistic approach to the alcoholic patient. These patients are very adept at recognizing a rejecting attitude. They frequently become non-cooperative after such recognition.

Results

We have used this method of treatment on 41 cases with uniformly good results. There were no deaths, no cases of delirium tremens and no complications of therapy. We have used no physical restraints since using this treatment. The average length of hospitalization was four days for the 41 cases.

As a follow-up, we attempt to refer all cases to the Sinissippi Mental Health Clinic, Dixon, Illinois and/or the H. Douglas Singer Zone Center in Rockford, Illinois.

Case Histories

Case Number 1. A 36-year-old man was admitted to the Amboy Public Hospital, February 10, 1968, because of vomiting, trembling, and extreme nervousness. History revealed that the patient had been drinking a fifth of vodka, and several six-packs of beer daily for approximately ten days. He was a red-faced trembling, agitated man. The remainder of the physical exam was negative.

He was immediately given 10 mgm of diazepam intravenously, and an intravenous solution of 10% glucose in Polysal-M with one ampule of Solu-B forte started. He required 120 mgm of diazepam to control his agitation the first 24-hours. He received 3000 cc of 10% glucose solution the first 24-hours, and 2000 the second

24-hours. By the third day, the patient was ambulatory and able to eat. He was discharged on the fourth day and referred to the Sinissippi Mental Health Clinic.

Case Number 2. A 62-year-old man was seen on a house visit on March 17, 1970, because of a generalized convulsion. An airway was inserted, he was given 10 mgm of diazepam intravenously, and was transported to the hospital by rural fire department ambulance. His history was that of drinking at least a pint of wine daily for many months; but on the day of the convulsion, he was unable to obtain his usual supply.

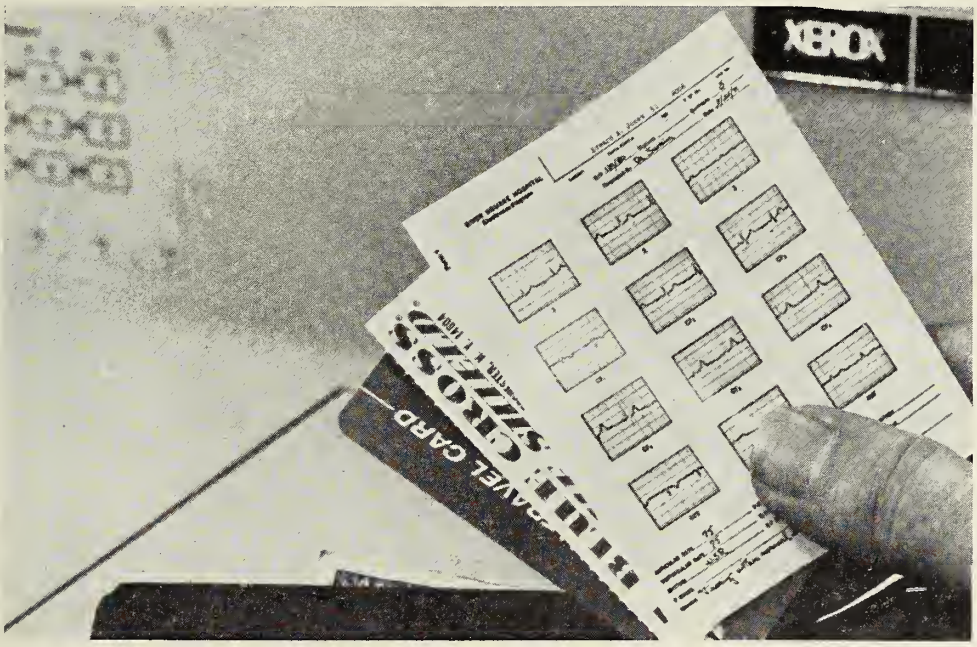
He was given 10 mgm of diazepam intramuscularly on reaching the hospital and a 10% glucose solution in Polysal-M with an ampule of Solu-B forte. His convulsions stopped within one hour after reaching the hospital, and he was able to eat after 12 hours. He received 80 mgm of diazepam the first 24-hours, and he recovered rapidly after cessation of the convulsions.

Summary

A simplified treatment plan for the treatment of acute alcoholism was used on 41 cases with uniformly good results. It uses drugs readily available in any hospital. The cornerstone of this plan is the use of diazepam by the most convenient route of administration, and in large enough doses to control the abnormal behavior patterns of the acute alcoholic. ◄

References

1. "Physicians Desk Reference," *Med. Econ.*, Litton Publications, Oradell, New Jersey, p. 1052, 1969.
2. Mendelson, Jack H., "Biologic Concomitants of Alcoholism," *New Eng. J. of Med.*, 283, p. 24, 1970.



Mini electrocardiogram designed for heart patients

Carried by heart patients, this minature electrocardiogram can help insure proper emergency treatment. In the wallets of persons with normal health, the wallet-sized card can help prevent over-treatment of emergency patients with other ailments. Doctors say the card also could help avoid unnecessary assignment of hospital beds.

For additional information on this subject call or write: Robert L. Stearns, Xerox Corporation, Xerox Square 006, Rochester, N.Y. 14603 (716) 546-4500, Ext. 4265.

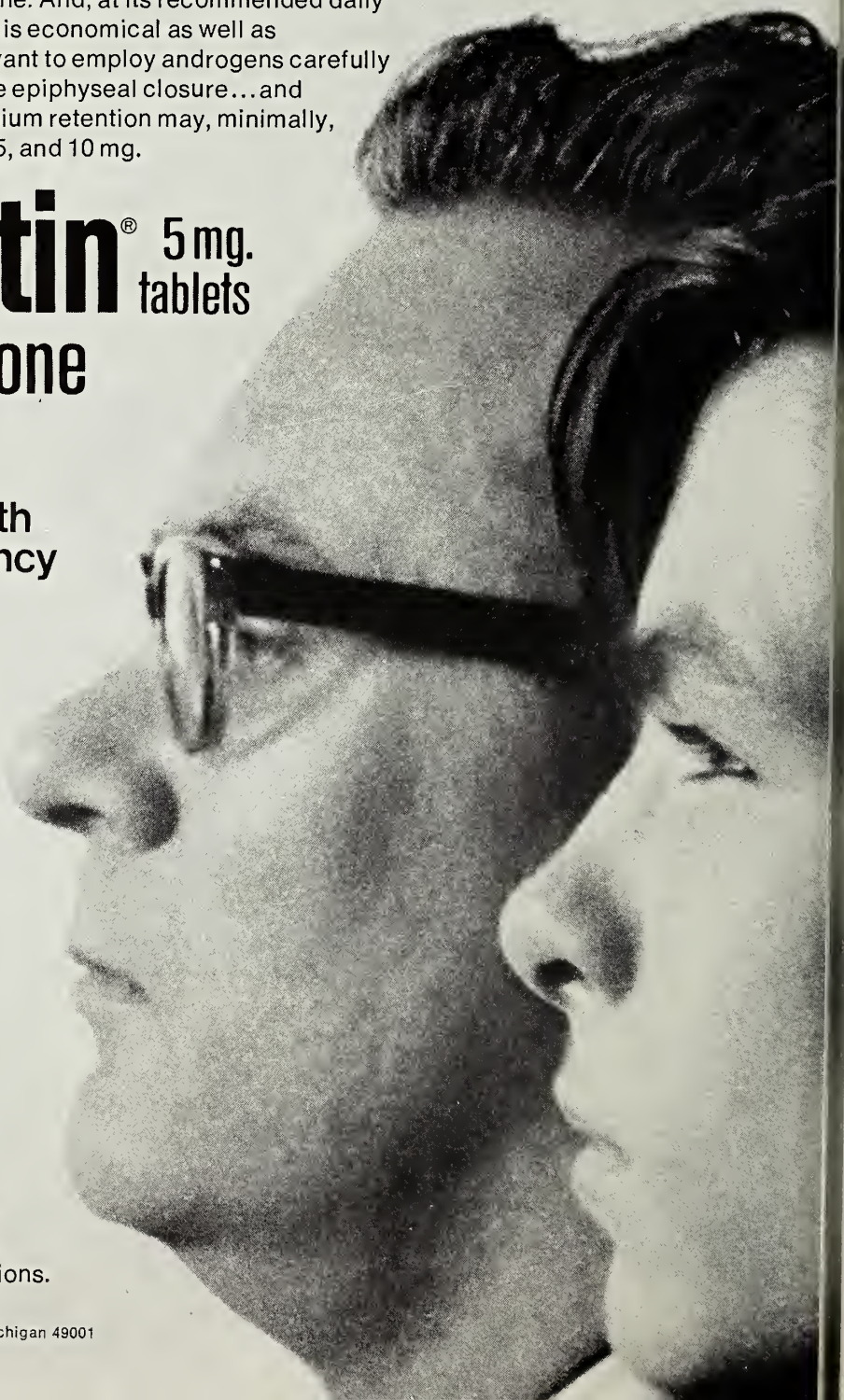
when manhood ebbs... or is delayed due to testicular hormonal insufficiency

What nature denies, Halotestin may replace. That's the purpose of this orally active androgen in conditions such as impotency, eunuchoidism, and eunuchism. The most widely used agent of its kind, Halotestin is replacement therapy with approximately five times the potency of oral methyltestosterone. And, at its recommended daily dosage of 2 to 10 mg., Halotestin is economical as well as convenient. Of course, you will want to employ androgens carefully in young boys to avoid premature epiphyseal closure... and in the elderly where possible sodium retention may, minimally, precipitate edema. Tablets of 2, 5, and 10 mg.

Halotestin® 5 mg. tablets

(fluoxymesterone Upjohn)

oral replacement with parenteral-like potency



Please see facing column for summary of contraindications, precautions, and adverse reactions.

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

Halotestin®
(fluoxymesterone, Upjohn)

Orally active androgen about 5 times as potent in anabolic and androgenic activity as methyltestosterone. Halotestin (fluoxymesterone) induces significant retention of calcium and potassium, but retention of sodium not marked. Doses below 20 mg. daily have little effect in producing creatinuria.

Indications *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.

Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.

Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.

Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.

Supplied *Tablets: 2 mg.*, scored—bottles of 100./ *5 mg.*, scored—bottles of 50./*10 mg.*, scored—bottles of 50.

For additional product information, see your Upjohn representative or consult the package circular.

Upjohn The Upjohn Company, Kalamazoo, Michigan

JA68-7627-R MED 8-5-S (LQX)

Obituaries

Joseph A. Giello, Chicago, died September 9.

****Louis A. Heely,** Belleville, died September 3, at the age of 87. He served for 32 years as a physician prior to his retirement in April, 1967.

****Benjamin H. Hilkevitch,** Chicago, died September 22, at the age of 84. He was a professor emeritus of Rush Medical College and the University School of Medicine. He practiced medicine for more than 50 years.

***John G. Hillebrand,** Chicago, died September 19.

***Erwin M. Japha,** Glencoe, died September 1, at the age of 60. He was the director of the Department of Therapeutic Radiology at Mount Sinai Hospital.

Nicholas J. Menolasino, Lake Forest, died September 8, at the age of 44.

****Rudolph J. E. Oden,** Lincolnwood, died September 14, at the age of 89. He served for 48 years as a surgeon at the Augustana Hospital and was a professor of surgery at the University of Illinois.

Allan F. O'Hanley, Calumet City, died September 26, at the age of 62. He was the examining physician at the Baltimore and Ohio Railroad for 22 years.

****Ralph Waldo Trimmer,** Oak Park, died September 8, at the age of 77. He had been on the medical staff of the Rush Medical School and Presbyterian-St. Luke's Hospital for 49 years.

****Hans Uterhart,** Melrose Park, died September 14. He practiced medicine for 63 years.

**Member of ISMS*

***Fifty Year Club member*

"Vascular Disease" film offered

"Vascular Disease: Current Technology and Diagnosis" has been released by USV Pharmaceutical Corp.

Dr. Travis Winsor, well-known authority in the field of vascular disease, presents physical examination procedures and certain modern techniques for assessing the adequacy of circulation. All procedures are enacted with patients having vascular disorders.

Contact USV Pharmaceutical Corp., Tuckahoe, N.Y. 10707, Attn: Sales Admin. Dir., or your USV representative for further information.



practice management

Buying a medical building: A sound investment?

By Robert P. Revenaugh
Professional Business Management

Recently, one of our clients asked our opinion concerning the buying of a medical building in which he would also be a tenant. He liked the idea of the control he would have, had heard there were certain tax advantages and he felt that real estate would make a nice addition to his investment portfolio. With over 15 years of experience in answering such questions, we have learned that the best answer is to pose another question. Is the doctor's primary purpose to make a good financial investment or is it so he can have a more efficient office in which to practice?

As a financial investment, we would prefer that he invest in commercial or apartment property. We gave several reasons:

- A medical building is usually a single purpose building. Often each room contains expensive plumbing. The rooms are small. More space is devoted to parking than would ordinarily be provided for in a general office building. Because of these rather unique characteristics, the building is not easily converted to general office use. Whereas the location of the building may be ideal for a medical practice, it may not be appropriate for general offices. When a doctor buys a building which may have a useful life of 30 years he should consider that he may someday be required to sell it. The special purpose building limits the market considerably.
- Because sale for conversion to general offices may be difficult, the most likely buyer is another doctor. However, the number of doctors available to purchase at the time you are willing to sell may be limited. Furthermore, it seems that when one doctor in a community builds his own building, others in the same community do likewise, thus further shrinking the available market.
- Another consideration involves crystal ball gazing. What will the private practice of medicine be like in 20 or 30 years?
- Most multi-doctor buildings are not structured to make a profit. They usually are restrictive on the addition of new tenants, and their buy-out provisions are restrictive as well. Valuation of one's interest in the event of a buy-out is likewise difficult to ascertain.
- A medical building located adjacent to a hospital might represent an exception to the general rule that medical buildings are not a good financial investment. If medical practice continues to be more closely associated with the hospital, the building may increase in value because of its desirable location for physicians or because the hospital may need the location to expand.

From an investment standpoint a doctor may be better advised to invest in other real estate with a broader market, but from a practice standpoint, a medical building may represent the best investment a doctor could ever make. If he doesn't otherwise have proper space available to him for rental at a reasonable rate, he should seriously consider being part of a building. Invariably, doctors moving into their own well-designed space from cramped quarters increase their income considerably in spite of their increased costs. There are several reasons for this:

(Continued on page 540)

Management of Parkinson's Disease

(Continued from page 492)

tient both gratifying activity of value to some one other than himself as well as that which is for his own enjoyment. This is one of the most difficult aspects of treatment owing to the great variation in patient interest and the tendency of many parkinsonian patients to resist socializing.

Responses in cases of postencephalitic parkinsonism are highly variable and rather difficult to predict, and such patients, in one's own experience, are included among some of the worst and best results. Demented patients and patients with non-parkinsonian movement disorders including "arteriosclerotic" parkinsonism, spasticity, pseudodulbar palsy, amyotrophic lateral sclerosis, and multiple sclerosis simply do not do well and there seems little point or purpose in treating them with l-dopa. Our own efforts with dystonia musculorum deformans have proved fruitless. The motor manifestations of Huntington's chorea regularly are made worse by l-dopa. Patients who have undergone surgery for the relief of parkinsonism may display marked asymmetry of response with the development of rigidity or dystonia in the limbs opposite the site of operation, but previous surgery should not be regarded as a contraindication to l-dopa.[2,5]

L-dopa and other drugs

L-dopa may be used in conjunction with other antiparkinsonian drugs including amantadine but it is usually possible to manage the patient on l-dopa alone, the latter being one's own preference. If multiple drugs are used, the required dose of each may be somewhat lower. If other antiparkinsonian drugs have been used and their withdrawal planned in conjunction with l-dopa treatment, the change should be made gradually lest withdrawal rigidity occur. Correspondingly, whenever dopa itself is to be withdrawn, it should be done as slowly as possible and if it cannot be withdrawn gradually, another drug such as amantadine, trihexiphenidyl or benztropine mesylate should be started to prevent withdrawal rigidity. Amantadine HCl in doses of 200 mg or less per day has been found useful as an antiparkinsonian drug. Its effect appears to be related to its anti-cholinergic properties. It has two important side effects, namely, urinary retention and visual hallucination. Since adding amantadine to patients receiving maximal benefit from dopa makes no difference and since very few patients are incapable of tolerating dopa, there seems relatively little place for this drug.[11,12]

The combination of l-dopa and alpha methyldopa may result in paradoxical circulatory disturbances or exaggerated neurological or psychiatric responses of a variety of patterns. It would seem wise not to combine the two agents. L-dopa appears ineffective treatment for drug induced parkinsonism which responds much better to benztropine mesylate, trihexiphenidyl, or procyclidine. L-dopa should not be used with psychoactive drugs including monoamine oxidase inhibitors or sympathicomimetic drugs owing to unpredictable excitement secondary to enhanced levels of norepinephrine.

Parkinsonian patients receiving l-dopa who require surgery probably should be transferred temporarily to another drug or withdrawn. At this time drug interactions are not well documented. Patients generally can be returned promptly to a previous dosage level without the need for prolonged titration. However, whenever presented the opportunity, it is probably worthwhile to try to carry the patient at lower doses.

We have had no experience with l-dopa overdosage. Should it occur, the usual supportive measures for overdosage of any orally ingested agent should be instituted including cardiac monitoring and provision for dialysis.

Summary

As indicated above, l-dopa can and should be attempted in all patients with paralysis agitans and postencephalitic parkinsonism in whom there is no medical contraindication. A treatment trial is justified in the most severely disabled as well as those who are post operative. It is anticipated that about two-thirds to three-fourths of the patients will show moderate to marked improvement with an occasional patient losing most of the symptoms and signs of the disorder.[2-6] The majority of the remainder show lesser degrees of improvement and nearly 90% of all patients show some benefit from l-dopa. Only a few (usually severely disabled) patients

(Continued on next page)

show no effect or worsening. In them little is gained by continuing medication and one is best advised to maintain them by attention to nutrition, care of the skin, maintenance of range of motion, and the opportunistic use of anti-parkinsonian drugs. The important steps appear to be to identify and treat patients prior to severe disability. ◄

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Make peace not war

". . . My generation is perhaps frozen in its pattern of behavior but the younger one is not—yet! I hope they will not become discouraged and disillusioned by the inevitable rebuffs and the slow pace of reform and progress.

"I can only make the feeble suggestions that (1) we quit making hollow promises to ourselves that we will 'abolish war,' the way we did with the Kellogg-Briand pact; (2) we maintain a world in which many ways of life are not only permissible but respected; (3) we reorient history to glorify things other than war—teach peace not war; (4) we teach children that discipline and obedience are not fixed values in themselves but modifiable and become virtues only when used to achieve common goals in the interest of all mankind; (5) we accept the view that the fundamentals of democracy are not hopelessly wrong but if modified, some drastically, a workable system will ultimately arise; (6) we insist that the leaders of people, i.e., the governments, remove their medals and striped trousers and come much closer to their constituents, more to represent than to govern them; (7) we strive for peace with the same dedication and wholeness with which war has been until recently prosecuted; (8) we restore confidence that man can do the impossible; (9) we teach values as well as skills in our schools; and (10) lastly, we unite with all people to pursue the goal of common survival and progress. The night of our inhumanity has already been too long." (Irvine H. Page.: **War. Modern Medicine** (Editorials) (Aug. 23) 1971, pgs. 51-54.)

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ekg of the month

(Continued from page 499)

Answer:

5. *None of the above.* The tracing shows pre-excitation syndrome (Wolff-Parkinson-White Syndrome). The characteristic features are the short PR interval, prolonged QRS and delta waves as seen in multiple leads. Abnormal Q waves or QS deflections occur frequently during pre-excitation and should not be confused with presence of myocardial infarction. Repolarization abnormalities are also frequently seen and their significance uncertain. The W-P-W syndrome is probably congenital in origin and may often be seen in healthy persons. Supraventricular arrhythmias are common and are said to occur in 40 to 80% of cases.

practice management

(Continued from page 534)

- A good location with convenient parking is attractive to patients.
- Doctors have an opportunity to plan an efficient space to their own specifications. This increased efficiency reflects in a greater ease of practice and a greater net income.
- Through greater efficiency it is not at all unusual to witness a ten percent increase in practice income. At that rate, the building may well be paid for in ten years. Even if the building is worthless at the end of 20 years, it may have been worth every cent to the doctor through more adequate office space.
- Even if the building will not produce a greater net income for the doctor, it may still be worthwhile to him over a period of time if it provides him with a greater ease of practice. Most doctors are in a high tax bracket. If the tax people share in his profits, they might likewise share the cost of a comfortable, convenient and efficient office space.

On balance, the doctors whom we serve that own their own medical buildings—built to their specifications—feel that it has been very much worth while from a practice standpoint. Very few regret doing it. Most are not too concerned about the financial investment aspect because they feel they have obtained other benefits to more than offset any loss they might suffer upon resale.

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Safety for use in infants, children and pregnant women has not been estab-lished.

Precautions: The usual precautions should be observed with atopic individuals. Clinical effectiveness should be monitored to detect evidence of development of resistance of *N. gonorrhoeae.*

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Dosage and administration: Keep at 25°C and use within 24 hours after reconstitution with diluent.

Male—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be prevalent, initial treatment with 4 grams (10 ml) intramuscularly is preferred.

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the presidents page

We DO have some answers!

Our critics claim we physicians promoted a doctor shortage. They also say we are short on solutions.

How wrong they are! For years, Illinois physicians have been active in developing programs to ease the doctor shortage problem. Our most recent proposals were contained in a report developed after a six-month study by our ISMS Task Force on Physician Shortage.

The report was prepared in response to an Illinois Senate resolution approved last April. The resolution, sponsored by Senate president pro tem Cecil A. Partee, D-Chicago, asked for recommendations as to what the state can do to help solve health manpower distribution and shortage problems.

We came through with several definite—even dramatic—suggestions in our report.

First priority, we feel, is the establishment of a Division of Health Manpower Recruitment. This agency would be responsible for defining medically-deprived areas and recruiting physicians and other allied health personnel to serve these areas.

We believe the new division should be established as part of the state's Commission on Business and Economic Development. After all, health care is the most important industry in this nation since it involves everyone's health. The same amount of effort spent on recruiting in business and industry should be devoted to solving our health manpower problems.

Our task force also recommends that the new division have consumer representation. If the division is to be effective, it needs the cooperation of health professionals, state government and the public.

The report's most dramatic proposal involves development of a state-financed pilot project to provide a two-way closed circuit television hook-up between a doctor's office or university health center and an outlying "satellite" clinic in a small community. The "satellite" clinic would be staffed by a physician assistant or nurse.

A physician could hold daily 'office hours' with patients in medically-deprived areas. The television link-up would allow the physician to see and talk with the patient. The physician assistant or nurse could be ordered to take whatever tests are necessary. Cases needing more intensive care would be transferred to the "satellite" clinic.

These are just two of the proposals contained in our report. We also believe the state should:

- Support expansion of innovative medical educational programs such as the ISMS-supported MECO program, to interest students in opportunities available in community medicine.
- Provide scholarships and living expenses for qualified medical students who agree to practice in rural, small town or ghetto areas.
- Pass legislation to improve the Illinois medical climate by removing the danger of unwarranted malpractice suits.
- Expand residency and internships to appropriate hospitals throughout the state so younger doctors can be exposed to the challenge and rewards of community medicine.

The task force report proves one thing—our critics are wrong! We may not have all the answers to the shortage and maldistribution of physicians, but we do have some practical proposals—Proposals which have worked in Illinois and in other states.

L. J. Fuerst M.D.

(Ed. note: See page 597 of this issue for more on the ISMS response.)

BLUE SHIELD REPORT FOR *Illinois Physicians*

BC–BS Benefits Broadened For Steel Employees

Improved hospital and medical-surgical benefits for employees of four major steel companies were part of the results of contract negotiations held last summer. These new benefits became effective August 1, 1971 for employees of Armco Steel (IMS groups #40568 and #41467), Bethlehem Steel (group #70001), U.S. Steel (group #70002), and Jones and Laughlin (groups #70003 and #70100). The improved surgical-medical benefits include:

• Emergency Accident Care—Benefits are available for emergency accident care wherever performed if treatment is given within 48 hours of the injury. The date of injury should be indicated on the Physician's Service Report.

• In Hospital Medical Days—Benefits were increased to 365 or 730 days depending on the length of service of the employee for regular surgical-medical admissions. Medical days for care of mental or nervous conditions, alcoholism, drug addiction, and pulmonary tuberculosis have been increased to 60 days in any 12 month period.

• Diagnostic X-Rays—Benefits for diagnostic x-ray services have been increased to a maximum of $150.00 in any 12 month period.

• Diagnostic Exams—Benefits for diagnostic examinations (EKG, EEG, BMR, and Isotope studies) have been increased to a maximum of $150.00 in any 12 month period.

• Dental Surgery—Out of hospital benefits are now available for dental procedures previously covered only in hospital except:

1. Out of hospital benefits for surgical removal of impacted teeth, partially or completely covered by bone, are for hard tissue impactions only. Both soft and hard tissue impactions are covered in hospital.
2. Alveolectomy is covered out of hospital only when performed as an independent procedure. Alveolectomy performed at the time of teeth extraction is not covered *out of hospital.*
3. Gingivectomy is not a benefit either in or out of hospital.

• Over 65 Benefits—On assigned claims, the total allowance will not exceed the reasonable charge as determined by the Part B carrier. On non-assigned claims, the allowance will be the Usual and Customary allowance less the amount paid by Medicare.

• Other Benefits—Sterilization procedures are in benefit regardless of the medical necessity.

GROUP MDs SEE MORE PATIENTS

The typical group physician sees 20 percent more patients than does the solo practitioner, including nearly twice as many in the hospital setting, according to *Reference Data on the Profile of Medical Practice*, published by the American Medical Association. Only the doctor in a two-man partnership sees more patients. The figures are the results of 3,817 observations made by AMA surveyors in 1969 and published in the 122-page booklet compiled by the AMA's Center for Health Services Research and Development. The average clinic group physician charges more for an initial office visit than do doctors in solo, partnership or informal association practices, but his fee is lower for follow-up and hospital visits.

NEW TRUSTEES FOR BLUE SHIELD'S BOARD

The Board of Trustees of Illinois Medical Service has been expanded to nineteen members as a result of our recent merger with the Medical Surgical Service of Illinois. There are now nine public trustees and ten medical trustees on the Blue Shield Board.

Mr. Matthew Cicero of Rockford was elected to fill the new public trustee position. Dr. Robert Stepto of Chicago was elected to the vacancy created among the medical trustees by the resignation of Dr. Burtis E. Montgomery. Mr. Robert J. Agnes was elected to the public trustee position formerly held by Dr. Stepto.

Other members of the Blue Shield Board include as medical trustees: Dr. C. Elliott Bell, Decatur; Dr. George B. Callahan, Waukegan; Dr. Joseph R. Mallory, Mattoon; Dr. V. P. Siegel, East St. Louis; Dr. Leo P. A. Sweeney, Chicago; Dr. Walter C. Bornemeier, Chicago; Dr. William De Hollander, Springfield; Dr. H. Close Hesseltine, Chicago, President-Chairman; and Dr. Alexander Ruggie, Skokie.

The public trustees include Mr. Henry P. Anderson, Chicago; Mr. Robert Walters, Omaha; Dr. Frederick L. Eihl, Moline; Dr. O. Kenneth Johnson, Chicago; Mr. Emil J. Koe, Park Ridge; Mr. George E. Tapling, Chicago; and Mr. Weir C. Swanson, Arlington Heights.

(This is not an advertisement)

THE ASSIGNMENT AGREEMENT—WHAT IT MEANS

Those who are familiar with Part B Medicare (the Supplementary Medical Insurance of the Health Insurance Program) know that there are two methods of claiming benefits under the program. The first is for the patient to claim payment for himself on the basis of an itemized statement. This is direct or non-assigned billing. Payment is made directly to the patient.

The second is the assignment agreement. This means that the patient can make an assignment of the unpaid bill to a physician *if both agree to this method of payment and agree to consider the allowable charge as full charge for the service.* When such an agreement is made, the patient and the provider of services have entered into a form of *contract* under which the patient's only responsibility of payment is for any portion of the unmet $50.00 deductible which is deducted from the allowable charge and the 20 percent coinsurance which is not paid by Medicare.

Any time that a physician who has accepted assignment bills a Medicare patient for any difference, other than the deductible and coinsurance, between his fee and the allowable charge as determined by the Medicare carrier or receives payment from a supplementary insurance carrier which, when combined with the payment received from Medicare, exceeds the allowable charge, the physician is in violation of the assignment agreement. Procedures have been established by the Bureau of Health Insurance under which the Bureau or the Part B carrier can take action to correct such violations. One such procedure is discussed further below.

There are three basic situations in which assignment violations generally occur. The first and most obvious is when the physician bills the patient for the difference or any portion of the difference between his fee and the allowable charge. An example of this would be: Dr. X's bill to Mr. Y is $300.00. Assignment is accepted. The carrier determines that $200.00 is the allowable charge for the services provided. As the deductible has been met, the carrier pays Dr. X $160.00 (80% of the allowable charge). Dr. X, disregarding the terms of the assignment agreement, bills Mr. Y $140.00 instead of the $40.00 coinsurance.

A second and more frequent type of assignment violation occurs when the physician *collects more than the allowed charge by a payment from a supplementary insurance carrier.* Using the above example, Dr. X submits a claim to Mr. Y's supplementary insurance plan. The supplementary plan processes the claim and pays Dr. X 20% of the total charge; in this case, $60.00. Since Dr. X has also received $160.00 from Medicare, he has been paid $20.00 more than the allowable charge of $200.00. A refund must be made either to the patient or to the insurance company depending on the terms of the supplementary policy held by the patient.

The third type of assignment violation is less obvious than either of the above. Since an assignment is a form of contract and is subject to the rules applicable to contracts in general, the assignment cannot be voided or withdrawn unilaterally. Nor can it be jointly voided or withdrawn once a claim has been paid. There have been some instances where physicians have attempted to circumvent the assignment agreement by having the patient sign a separate assignment or promissory note in which the patient agrees to pay the total difference between the billed and allowed charges. This is, in effect, a negation of the assignment agreement. Where such practice is followed, carriers have been instructed to treat all claims for services by that physician as non-assigned claims and payment will be made directly to the patient.

Patients can be billed, however, for *non-covered services* even when the assignment method of billing has been used. Charges for services which have been disallowed as non-covered under Part B Medicare, such as routine physical examinations, unnecessary services, flu shots and other preventive vaccinations, most Vitamin B-12 injections, and medicines, are the patient's responsibility.

ASK BLUE SHIELD
• • • ABOUT MEDICARE

THE PART B MEDICARE DEDUCTIBLE AND THE DEDUCTIBLE CARRYOVER

Persons eligible for Part B Medicare benefits must meet a deductible of $50 in each calendar year before payment can be made for covered expenses. Even if a person is not eligible for the entire calendar year, the full $50 must be met. Noncovered expenses do not count toward the deductible.

Expenses which are incurred during the months of October, November, and December which are applied toward the deductible for that year may be applied toward the deductible for the following year. Thus, a charge of $30 incurred in October 1970 which is applied toward the 1970 deductible may also be applied toward the 1971 deductible, leaving $20 of the 1971 deductible still to be met. However, if a patient satisfies the deductible through expenses incurred prior to October 1 of a given year, charges incurred after October 1 are not applied toward the deductible and the entire $50 deductible for the following year must be met before benefits can be paid.

* * * * *

Notice—Gerson Clinical Laboratory, 1016 North Asland, Chicago is certified for Medicare participation. As per our notice last month, a second office at 1 North Pulaski, Chicago has been decertified.

(This is not an advertisement)



editorials

'Tis the season for humility and charity

Charity, the spirit of Christmas, is the keystone of the arch of medicine. We like to think that science is one of the supporting pillars and that the art of medicine is the other. Charity must remain uppermost in our attitudes; without it, scientific progress will soon become meaningless in our relationship to the laity.

For several years, organized medicine has been severely criticized. So much so, that many of us no longer are proud to be physicians or can recommend the study of medicine to promising students. The world we are asked to serve and accept seems to lack sanity and purpose.

But there is a bright side in that over the centuries, those willing to serve mankind have usually come out on top. Governments come and go, but physicians will remain forever, so long as sickness, disease, and accidents continue. Medicine as a profession existed long before the dawn of Christianity. Frankincense and myrrh were ancient remedies.

We can profit from the spirit of Christmas. Take stock of your activities and goals and set your sights on higher levels. And, always remember, there are rewards for a job well done. Good decisions are not always popular. It may take courage, but Christmas will provide the hope that gives meaning and value to life.

The great resurgence in medical thought, knowledge, and technology should not overshadow our basic assets—humility and charity.

Merry Christmas,
T. R. Van Dellen, M.D.
Editor

Guest editorial

" Pollution in physician's environment"

Can physicians continue to absorb the ever growing flow of unsolicited medical journals which reach them monthly? If my own experience, that of my associates, and the letters I have been receiving are any indication, I don't think so. That other editors are hearing from their readers is shown by this report from the June issue, *Journal of the Florida Medical Association:*

"Aware of the pollution of doctor's desks by unsolicited medical publications, one practitioner was prompted to collect, assess and weigh all medical advertising magazines and periodicals he received in a month. He arrived at the total of 30 pounds. Assuming that this same amount is sent to each of the 200,000 practicing physicians in the United States, it would amount to 3,000 tons a month. At a reading speed of 15,000 words per hour, scanning this literature would require 160 hours a month or approximately 40 hours each week, and could only be done by a retired physician, and who, relieved of the burden of his practice, is not encumbered by time-consuming hobbies or the affairs of organized medicine."

Well, what can be done about it? The answer depends to a large extent on what action physicians—and medical journals—take during the next few crucial years. In your interest and mine, *Medical Times* has been doing something about it for the past 11 months by converting to "request" circulation in the following manner. . . .

A form letter was sent to every physician who has been on the *Medical Times* circulation list

(Continued on page 569)







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1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 196

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

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Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.
Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.
Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.
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For additional product information, see your Upjohn representative or consult the package circular.

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JA68-7627-R MED B-5-S (LQX)

Physician's Pollution

(Continued from page 559)

twelve months or longer. (When our newer readers have received *Medical Times* for 12 months, they, too, will receive the "request" letter.)

I became even more deeply concerned, however, when hundreds took time to write me about the "pollution" of the physician's environment. These letters indicated a concern so serious that I decided to probe further into this type of office "pollution." Therefore, 2,400 questionnaires were sent to a random sample of *Medical Times* readers. They were asked just one question: "If it were possible to do so, how many of these unsolicited journals would you like to have discontinued?" More than 56% of the physicians replied to my letter. The answers ranged from one extreme to the other, but overall they indicated that . . .

these busy physicians would prefer not to receive almost two thirds of all unsolicited journals.

Judging from the hundreds of comments received, most physicians agree that there is some good material in practically every journal . . . *but they just do not have the time to absorb the dozens of issues they receive monthly.*

- The Norwegian explorer Thor Heyerdahl reported there were days when his crew could not bathe in the middle of the Atlantic because of the pollution.
- Jacques Cousteau reported seeing newspapers on the floor of the Mediterranean.
- Lake Erie is considered by some ecologists to be a dead sea.
- Thousands of miles away, the Baltic Sea is equally crippled by pollution.

It would be nonsensical to contend that the pollution of the doctor's environment which we have described belongs in the same category as these. I make the comparison only because in each area *there is an inability to absorb!* (And on top of all this, would you believe that shortly *you're going to be receiving at least five more new journals!!!*)

"Pollution" of the physician's environment by too many unsolicited journals and their consequent disposal problem can be overcome with imagination and determination.

By Charles A. Ragan, Jr., M.D.,
Editor-in-Chief *Medical Times*

Abstracts of Board actions

Board of Trustees meetings

Rockford, Illinois
October 9-10, 1971

JCAH Workshops

The Board of Trustees approved plans for ISMS to co-sponsor two separate one and one-half day workshops on the revised standards for accreditation of hospitals. One of the programs will be April 6-7, 1972 in Springfield and the other April 12-13, 1972 in Chicago. The workshops will be conducted entirely by JCAH, which will charge a $35 registration fee.

Cancellation of *Pulse* Sponsorship

Dr. Reisch informed the Board that Roche Laboratories—which has underwritten the cost of publishing the ISMS newsletter, **Pulse**, for six years—has withdrawn that support and that publication may be discontinued after the December issue unless another sponsor is found.

Proposed Legislation

The Board of Trustees approved support of the following proposed legislation:

A. A statute of limitation on malpractice suits at three years after the date of actual injury.
B. Reducing the statute of limitations for foreign substances negligently left in the body from ten to five years after treatment.
C. Prohibiting the invoking of the doctrine of res ipsa loquitur in malpractice suits.
D. Calling for verification of pleadings in malpractice suits.
E. Requiring plaintiffs in malpractice cases to post a $500 surety bond.
F. Extending the Good Samaritan concept to any emergency situation on the premises of a hospital.

The Board also authorized the Governmental Affairs Council to submit to the legislature during the fall session a joint resolution requesting the Illinois State Bar Association to establish reasonable guidelines for the detection and elimination of nonmeritorious medical malpractice lawsuits and the discouragement of contingency fees in such cases.

Support also was voted for H. B. 2413, Drivers License Medical Advisory Board legislation, provided it is not amended to make it mandatory that at least one member of the board be an optometrist, and for H. B. 1553, which prohibits home rule units from licensing occupations already licensed by the state. A resolution lauding Rep. Brian Duff, who introduced the latter bill, was voted by the Board.

Illinois Foundation for Medical Care

The Board approved ISMS employment of necessary personnel to start up the Illinois Foundation for Medical Care. The services of these people will then be sold to the Foundation, which is a separate corporation distinct from the medical society.

Financing Phase II of FMC

The Board approved a Finance Committee recommendation that a $70,000 line of credit be established for the Illinois Foundation for Medical Care to initiate Phase II of its program. The loan was approved for one year, with the provision that no more than $12,000 could be borrowed per month.

Anti-Substitution

An ad hoc committee has been appointed to meet with the Illinois Pharmaceutical Association relative to IPhA efforts to amend or repeal the Illinois anti-substitution statutes. Paul W. Sunderland, M.D., will head the committee, which also includes Drs. Robert Muehrke, A. E. Livingston, William Walton, and William Lees.

Ad Hoc Committee on Manpower

In an effort to resolve problems pertaining to the state's health manpower shortage—and the controversy surrounding certification and licensure—the Board has approved the following to serve on an ad hoc committee to meet with the Illinois Hospital Association: Drs. Frank J. Jirka, Jr., chairman, Julian Buser, Kenneth Schnepp, Ross Hutchison, Jack Gibbs, and Joseph Bordenave.

Retroactive Denial of Medicare Benefits

Concerned over increasing complaints regarding retroactive denial of benefits to Medicare patients, the Board authorized preparation of a sample letter or envelope stuffer for purchase by physicians to educate their patients on the vagueness and inconsistency of the Medicare law and encourage them to register Medicare complaints with their congressmen and senators.

Health Insurance Forms

When it was reported that Blue Shield has been refusing to pay claims submitted on forms other than Blue Shield's, the Board said it would remind Blue Shield that official ISMS policy calls for use of approved Health Insurance Corporation standardized forms.

House of Delegates Procedures

Acting on recommendations of an ad hoc committee to study House of Delegates procedures, the Board said that, in order to be published in the **Illinois Medical Journal,** resolutions must be submitted nine weeks before the opening of the House, (January 3, 1972). Those resolutions submitted from four to nine weeks in advance of the meeting will be distributed to delegates separately, but that resolutions received less than four weeks ahead (February 8, 1972), will be considered only if approved by a House of Delegates Committee consisting of the Speaker, Vice-Speaker and one delegate each from downstate and Chicago. If this committee refuses to accept a late resolution, it will require a two-thirds majority of the House to have the resolution presented for consideration and reference. The Board also approved a plan to require councils and committees to submit resolutions when requesting House action rather than include them in annual reports.

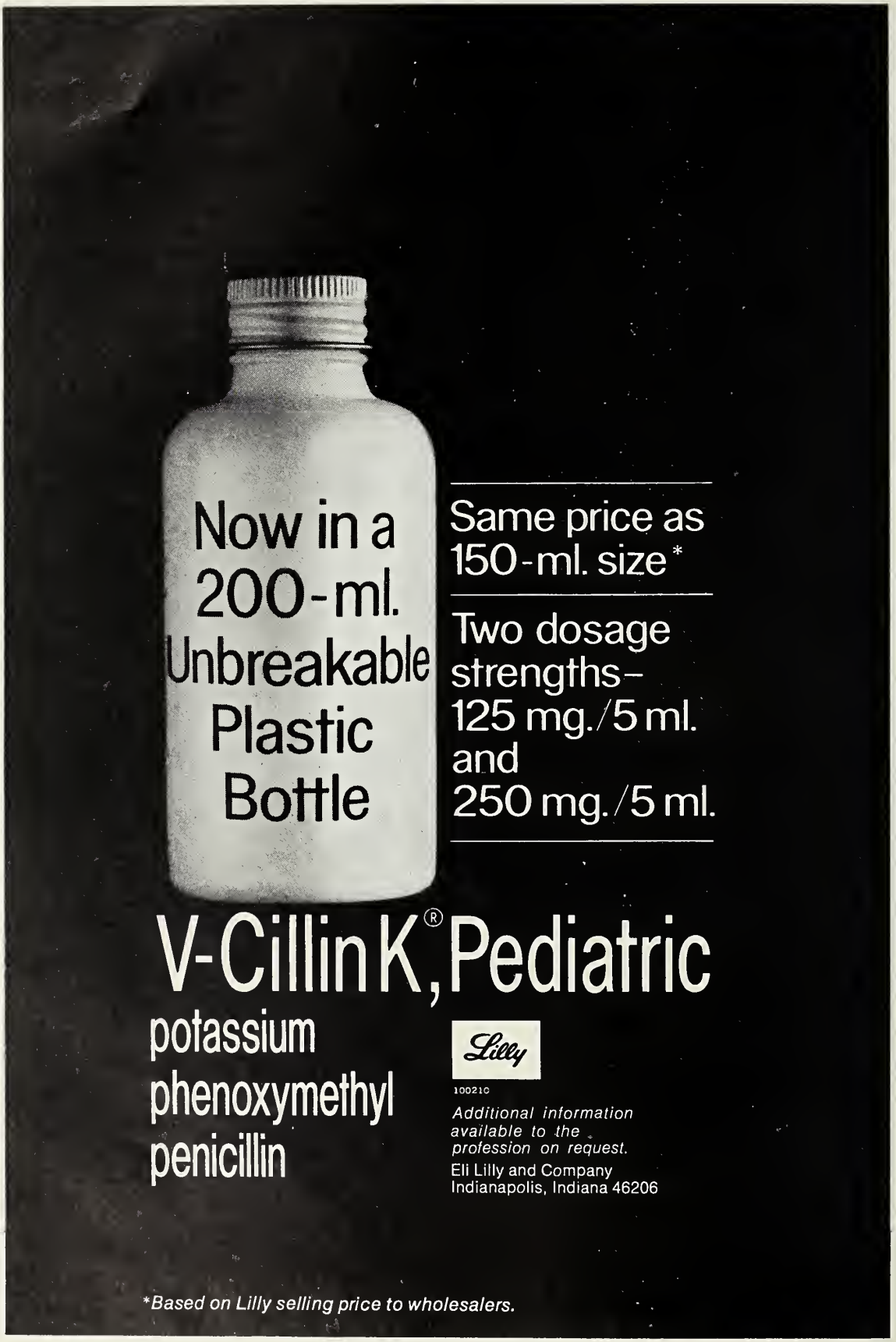
Policy Manual

Dr. Joseph Bordenave told the Board that the Policy Committee had attempted to divide ISMS policies into administrative and ethical sections for publication in the Policy Manual, but that this had not been deemed practical. The Board accepted 11 of the committee's recommendations for additions to the policy manual. These will be published in the **Illinois Medical Journal** prior to the annual meeting in March.

Constitution and Bylaws

Dr. Charles K. Wells reported that amendments authorized by the last House of Delegates have been incorporated into the 1971 edition of the Constitution

(Continued on page 601)


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Same price as 150-ml. size*
Two dosage strengths– 125 mg./5 ml. and 250 mg./5 ml.
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IMJ
Illinois Medical Journal

By Ronald D. Greenwood, M.D. and Howard S. Traisman, M.D./Chicago

Diabetes mellitus with peripheral and autonomic neuropathy: Case report of a child

DIABETES MELLITUS is the most common endocrine disorder in adults and children. It affects between one and two percent of the population; children with diabetes constitute four to five percent of that number.[1] The complications of this disease are protean. One of these, neuropathy, is common in adults and has, in fact, been considered not a complication but an integral part of the syndrome of diabetes mellitus.[2] Diabetic neuropathy occurs uncommonly in children. We are presenting a diabetic child with both peripheral and autonomic neuropathy.

Case Report:

K.T., a 18-year-old, Negro female with known diabetes mellitus since 1961, entered The Children's Memorial Hospital on May 14, 1969 with a three-week history of a burning sensation and numbness of both feet, a five-week history of a constant severe low back pain without radiation, constipation with bowel movements produced only by enemas at four to five day intervals, and inability to urinate with no knowledge of when her bladder was full. There was no history of motor weakness. She had previously been admitted to the hospital thirty-four times since 1961; the majority of her hospitalizations were for treatment of diabetic acidosis or regulation of her diabetes.

Her diabetes had been under fair control at the time of admission. She was receiving 52 units of Lente insulin, 22 units of regular insulin at 8 a.m., and 16 units of Lente insulin at 6 p.m., with a 2200 calorie diet.

This patient was born May 15, 1953, a six-pound product of a normal 38 week gestation. Delivery was normal as were the neonatal period and development. Immunizations were complete;

previous illnesses included hepatitis and monilial vaginitis. An appendectomy, tonsillectomy and adenoidectomy had been performed. Family history was negative for diabetes and neurological illness, and all three siblings (14-year-old male, 13-year-old male and 11-year-old female) were in good health.

Physical examination at the time of admission revealed a height of 57¼ inches (145.4 cm.) (<third percentile), a weight of 86¼ pounds (39.1 kg.) (<third percentile), pulse 140, respirations 24, temperature 99.4°F (37.4°C) orally and blood pressure of 144/108. Skin, head, eyes, ears, nose and throat, chest, heart, abdomen were all normal. Rectal examination was normal with good sphincter control.

Examination of the eyes revealed vision of 20/30 in the right eye and 20/30 in the left eye. The right eye revealed several microaneurysms between the disc and macula and several small hemorrhages infranasally and paramacularly. The disc and peripheries were normal with no exudate. The left eye was normal.

Neurological examination revealed cranial nerves to be normal; cerebellar and motor examinations were normal. Reflexes were normal except for a very hypoactive knee jerk on the left and a very hypoactive ankle jerk on the right with an absent ankle jerk on the left. There were no Babinski or Hoffman reflexes. Sensation including pain, temperature, vibrations, position, localization, two point discrimination and stereognosis were normal.

Laboratory findings

The complete blood count was normal; urinalysis was normal except for glucose and ketones. Blood sugars ranged from 124 to 340 mg% according to the degree of diabetic control. A quantitative 24-hour urine test for glucose revealed 5.15mg% of 1150 ml. or 59.2 gm/24 hours. Creatinine clearance was 59.3 ml./min./1.7 m^2. Cholesterol was 260 mg% (114-209 mg% normal). Serum BUN, creatinine, sodium, potassium, chloride, calcium, phosphorus, alkaline phosphatase and a protein electrophoresis were normal. Multiple urine cultures were negative and urinary VMA (3-methoxy-4-hydroxyl mandelic acid) was 0.

An IVP done one month previously was normal. X-rays of the lumbosacral spine were normal; and a myelogram was normal.

A lumbar puncture revealed no red blood cells, one white blood cell (lymphocyte); the CSF protein was 100 mg%.

A cystometrogram revealed a neurogenic bladder with a long low pressure curve with a lack of sensation and a capacity of 350 cc. When repeated with bethanechol chloride t.i.d. orally in preparation, there was no change; the administration of 2.5 mg. subcutaneously of bethanechol chloride ten minutes prior to the procedure produced no change. The residual urine was 15 cc.

Electromyography revealed the conduction time of the right ulnar nerve to be 53.1 m/sec. (normal 49-65), right peroneal nerve 42 m/sec. (normal 40-56.3), left peroneal nerve 44 m/sec. (normal 40-56.3). A needle electrode study (bipolar) of the proximal and distal right tibialis anterior muscle revealed a normal interference pattern and electrical silence with full relaxation (no fibrillation potentials and normal motor unit action potentials).

Treatment

Bethanechol chloride was prescribed and the patient improved and was discharged on May 29, 1969.

The girl was readmitted on June 16, 1969, for further evaluation of the same problem. At this time the findings were unchanged except for the additional findings of decreased vibratory sensation of the lower extremities and decreased quadriceps and gastrocsoleus reflexes. Blood pressure at the time ranged from 120/80 to 146/100.

She received Vitamin B complex, Vitamin B_{12}, and multivitamins with propoxyphene hydrochloride for pain as needed. Prior to discharge on June 24, 1969, the bethanechol chloride was discontinued, and the patient continued to void well.

This child was subsequently admitted on February 16, 1970 in diabetic acidosis. Examination of the eyes revealed no evidence of retinopathy except for one minute old hemorrhage along the superior nasal artery of the left eye, 3 disc diameters out. The remainder of the ophthalmic examination was normal. Blood pressure was 110/84.

On August 10, 1970, the patient was in good diabetic control receiving 40 units of Lente and 20 units of regular insulin every morning. Her blood pressure was 122/70. Medications consisted of multivitamins and Vitamin B complex. For approximately nine months she has been

free of bladder and bowel symptoms and paresthesias. The last eye examination on August 25, 1970 was normal.

Discussion

This child presented with typical juvenile diabetes mellitus which was difficult to control. In May, 1969, she displayed early simple diabetic retinopathy, hypertension, autonomic neuropathy (neurogenic bladder, constipation), and paresthesias. The electromyogram and nerve conduction velocities were normal but because of the differences in velocities between upper and lower extremities, these values were consistent with early mild peripheral neuropathy. Clinical evidence of neuropathies resolved by late 1969, when the diabetes was under much better control, and the retinopathy spontaneously resolved by February, 1970.

Neurological disorders associated with diabetes mellitus have been known since 1798[3]. Involvement of the nervous system is common; its exact incidence has been reported from 0.1% to 93%.[4-12] The criteria for diagnosis and the interest in making the diagnosis account for such a wide variation.

Diabetic neurologic manifestations include distal symmetrical polyneuropathy, mononeuropathy and radiculopathy,[13] cranial neuropathy,[14] amyotrophy[13,15] and autonomic neuropathy; diabetic myelopathy, myopathy and encephalopathy have been suggested, but thus far no specific examples have been substantiated.[13]

Peripheral neuropathy or distal symmetrical polyneuropathy is the most common neurologic disorder associated with diabetes.[13,16,17] Sensation is more affected than motor function. Numbness, burning, aching, paresthesias, diminished or absent vibratory sensation and position senses, loss of light touch and pain, and decreased or absent deep tendon reflexes are seen.[18] Motor involvement may be seen as muscle atrophy or foot drop.[13]

Autonomic neuropathy in adult diabetics is manifested as a number of different syndromes:[13,16]

1. Absent sweating, impairment of reflex vasoconstriction and dilatation, orthostatic hypotension, tachycardia and extremity redness as seen in the sympathectomy;
2. Excessive sweating, pallor and coldness of the extremities as in sympathetic overactivity;
3. Impotence;
4. Gastrointestinal disturbance seen as diarrhea, constipation, incontinence, segmental hypomotility of the small intestine, or gastric atony;
5. Pupillary changes are seen as sluggish or true Argyll-Robertson Pupils;
6. Urinary symptoms[19,20] such as urinary retention, bladder enlargement without retention, an abnormal cystometrogram (typically a long low pressure curve with lack of sensation) or an atonic bladder.

In one series, abnormalities in urinary bladder sphincter function were noted in 10% of patients with diabetic neuropathy.[21] Ellenberg and Weber[22] studied 30 diabetics with peripheral neuropathy and found 85% with unmistakable objective documentation of neurogenic bladder involvement.

Neuropathy in diabetic children is far less common than in adults. Several studies on diabetic neuropathy have included a few children but, in general, individual data are not given (Table I).

There are a number of authors reporting juvenile diabetes in the early adult years (ages 20 to 30) with neuropathy [3,11,25,29,31] and autonomic neuropathy has been reported in young diabetics in this age range.[32-33]



RONALD D. GREENWOOD, M.D., (left) is presently a captain in the U.S. Army Medical Corps and stationed at Fort Riley, Kansas. Dr. Greenwood was formerly a senior resident in pediatrics at The Children's Memorial Hospital when this case presented. He is a graduate of Northwestern University Medical School.

HOWARD S. TRAISMAN, M.D., (right) is an associate professor of pediatrics at Northwestern University Medical School, associate attending physician at The Children's Memorial Hospital, Division of Endocrinology, and head of the Diabetes Clinic. In addition, he is on the staffs of the Evanston Hospital and Chicago Wesley Memorial Hospital. A second edition of his book, THE MANAGEMENT OF JUVENILE DIABETES MELLITUS, is soon to be published.



Diabetes mellitus

Reports in children have shown varying incidences of neuropathy. Hoffman[34] found no evidence of peripheral neuropathy in 22 diabetic children when investigated with neurological examinations and nerve conduction velocities. Vibration sense has been studied in children with diabetes; it has been found intact in juvenile diabetics under 10-years-of-age;[35] in such patients between 10- and 20-years-of-age, however, approximately 41% were found to have evidence of vibratory depression.[35] Impaired vibratory perception was noted in children in other studies as young as nine to 10-years-old[36] and in children five to 20-years-old.[37] The symptom of pain, so often seen in adults, is rare in children.[36]

Table I
Reports of Diabetic Neuropathy Including Children

Investigator (ref.)	Type Series	No.	Ages, Comments
Mulder et al. (7)	103 D, NCV	2	11-19 range
Bonkalo (8)	74 DN	2	11, 17 yrs., females
Mayer (23)	D, NCV	?	ages 10-80, no data
Skillman et al. (24)	D, NCV	?	ages 12-87, no data
Rudy & Epstein (25)	100 DN	1	under 20 yrs.
Gregersen (26)	D, NCV	?	15-44 yrs., abnorm.
Gregersen (27)	D, VPT	?	15-44 yrs., abnorm.
Gregersen (28)	D,EMG	?	15-44 yrs., abnorm.
Martin (3)	150 DN	2	10-19 range
Jordan (11)	120 DN	2	<20 yrs.
Rundles (29)	125 DN	8	17-20 yrs.
Reske-Nielsen, Lundback (30)	Case Report	1	21 year old male
Broch, Klovstad (31)	88 DN	3	ages 15,18, 18 males

D—Diabetics
DN—Diabetics with neuropathy
NCV—Nerve conduction velocities
VPT—Vibratory perception threshhold
EMG—Electromyography

Peripheral neuropathy in children has been noted to be fairly common when carefully studied and especially when evaluated electrically. Lawrence and Locks[38] reported 13 children under 16-years-of-age with a distal bilateral polyneuropathy and two children with bilateral peroneal mononeuropathy. Gamstorp et al.[39] performed neurological examinations and nerve conduction velocities on 107 unselected diabetic children under 17-years-old from the patients of one of us (H.S.T.) and revealed 11 or 10% to have peripheral neuropathy. Eeg-Olofsson and Peterson[40] studied 85 children, two to 15-years-of-age with diabetes mellitus with no clinical signs of neuropathy or any complications of any type and compared them to normal controls. Pathologic conduction velocities were found in the ulnar nerve in two per cent and the peroneal nerve in nine per cent; the EMG was pathologic in five per cent (all lower extremities) and the EEG was pathologic in 35% (compared to a control of 13%). Gamstorp[41] studied 136 nerves in 23 diabetic children and found one peroneal definitely abnormal (mononeuropathy) and eight (one medial, seven peroneal) borderline low. Khalouf and Olsen[42] performed motor nerve conduction velocities on median and peroneal nerves of 20 diabetics from 5- to 23-years-of-age and showed a significant lowering. Included in their series of juvenile diabetics, Reske-Nielsen et al.[43] reported six diabetics, 16- to 21-years-of-age with a lowered mean conduction velocity in the peroneal nerve and an increased mean vibration threshhold; four of these had EMGs, two of which were pathologic.

Autonomic neuropathy in children is rare. Rundles[29] reports two patients with atonic bladders and severe constipation; one, a 20-year-old male with diabetes since age 14 had severe constipation, difficulty urinating, low back and flank pain. Examination revealed a flaccid bladder with a residual urine of 1100 cc., absent biceps, triceps, patellar and Achilles reflexes and tender atrophic muscles in his extremities. Cystometric examination revealed an atonic bladder without sensation. While under treatment, he developed a severe retinopathy. Within one year's time the retinopathy had improved so that only traces were present and urinary function had returned to normal.

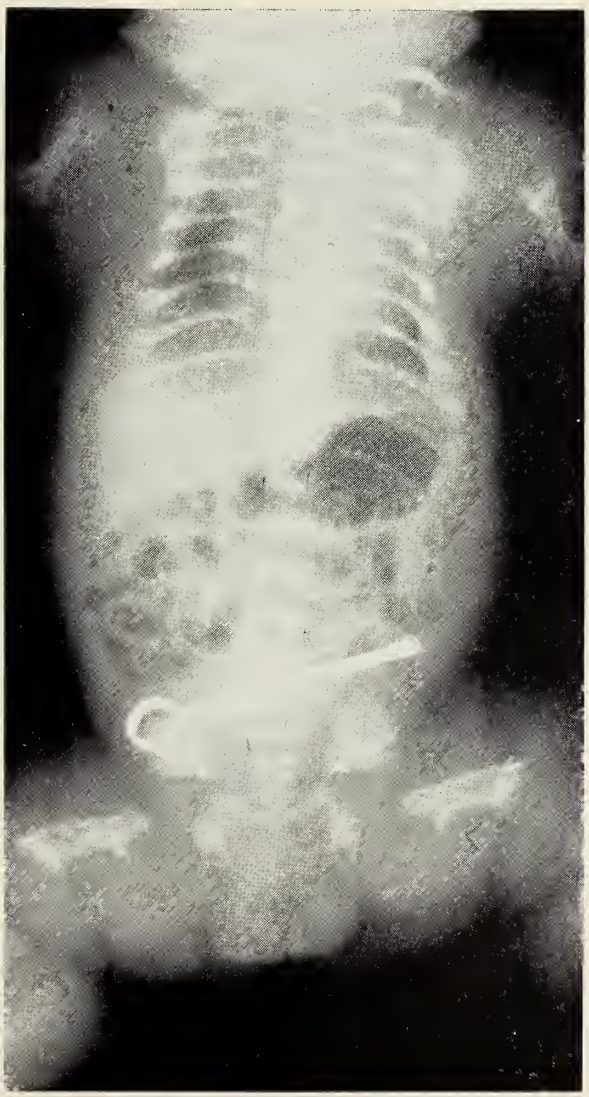
The second patient, a 19-year-old male with diabetes since 14-years-of-age, had severe constipation alternating with diarrhea, and peripheral neuropathy. Cystometrogram showed 750 cc. bladder capacity with a sense of filling at 450 cc., low expulsive pressure and no residual urine. In addition, there was a delay in small intestine motility. This patient did not improve with treatment.

Treatment of peripheral neuropathy includes thiamine and Vitamin B_{12},[44] but results may be disappointing. Parasympathomimetic agents or even bladder neck resection may be used for the atonic bladder.[17,21,45] Good diabetic control has been advocated by those who feel it is therapeutic; others feel it is not related to neurologic improvement.[44]

(Continued on page 616)

the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine



This newborn baby experienced severe respiratory disease at birth and died three days later. What's your diagnosis?
(See page 616)



surgical grand rounds

Surgical Grand Rounds are held weekly on Tuesday at 5 p.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 5, 1971.

Edited by John M. Beal, M.D.

Right hepatic lobectomy

Dr. George Case: A 68-year-old, white man was admitted to Passavant Memorial Hospital with a one week history of right upper quadrant and right flank pain. The pain was sharp in character, lasted two to three minutes and became increasingly severe. The pain was not related to meals, or altered by movement, but was accentuated by deep breathing. A history of neither renal or gallstones was present, and nausea, vomiting, diarrhea, constipation, change in bowel habits, jaundice, fevers, chills, weight loss were absent. Physical examination was within normal limits, with the exception of marked tenderness just below the right costal margin in the midclavicular line. The abdomen was soft, with normal active bowel sounds. The liver was enlarged to percussion. Rectal examination was normal.

Past History: The patient had been operated on in 1965 for a perforated carcinoma of the sigmoid colon, and a segmental resection had been performed. Laboratory findings included hemoglobin 13.4 gm., hematocrit was 42%, the white blood count was 11,850 with a normal differential. Serum bilirubin and amylase were normal.

After admission, an intravenous pyelogram was performed and was normal. The gallbladder did not visualize when cholecystography was performed. Barium enema was normal. Upper gastrointestinal X-rays were also done and revealed a small histal hernia.

The patient remained afebrile and the white blood count decreased to 8,300. Alkaline phosphatase, serum bilirubin, SGOT, total protein, fasting blood sugar, blood urea nitrogen and an EKG remained normal. A liver scan showed a



Fig. 1. Transected right lobe of liver demonstrates large tumor mass.

large mass in the right lobe of the liver. An exploratory laparotomy was performed December 8, 1970.

Dr. Stuart Poticha: Exploration of the abdomen was performed through a right subcostal incision. Evidence of recurrent tumor was not found either at the site of the previous colonic anastomosis or in the mesenteric or periaortic lymph nodes. The intra-abdominal organs were normal with the exception of the liver. Several large tumor nodules were seen and felt in the liver but the disease was localized to the right of the fibrotic gallbladder. Since the anatomic division between the right and left lobes of the liver extends from the gallbladder fossa to the inferior vena cava, the entire metastatic tumor appeared to be localized to the right lobe. The medial segment of the left lobe extends from the gallbladder fossa to the falciform ligament. A hepatic resection was planned which would include the entire right lobe of the liver and most of the medial segment of the left lobe. This extended right hepatic lobectomy would remove all of the tumor plus a wide medial margin of grossly normal liver tissue.

The resection was begun by incising the falciform, right triangular and right coronary ligaments. This mobilization allowed us to determine that the tumor did not invade the diaphragm, abdominal wall or inferior vena cava. The incision was then extended into the chest through the right seventh interspace. The diaphragm was incised from the costal margin to the supra-hepatic inferior vena cava. The right lobe was devascularized by ligating the right hepatic artery and the right branch of the portal vein in the hilum of the liver. After careful identification the cystic duct and the right hepatic duct were ligated and divided following which a long arm T-tube was inserted into the common bile duct with the long arm extending well into the left hepatic duct. I believe that the insertion of a T-tube is an important technical point in hepatic resections. First and most importantly continued palpation of the tube helps the surgeon protect the left hepatic duct. Without a tube injury to the left hepatic duct its disastrous sequellae can easily occur when the liver parenchyma is later divided. Secondly, as Merendino has pointed out, drainage of the common duct prevents increased pressure in the biliary system when the sphincter of Oddi contracts. This reduces the incidence of post-operative biliary leaks from the cut liver surface. The operation was completed by placing a double row of interlocking catgut sutures just to the right of the falciform ligament. Using blunt dissection, the liver parenchyma was divided between the two rows

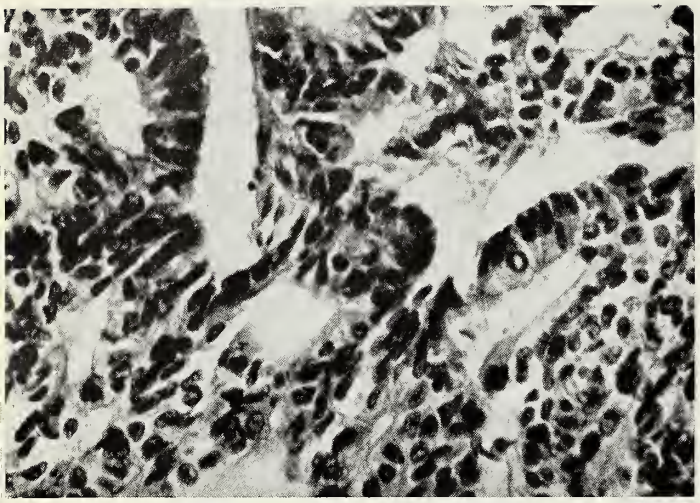


Fig 2. Microscopic study of the tumor shows that adenocarcinoma is present.

of sutures. Small ducts and vessels were suture ligated and divided as they were encountered. Superiorly, the large right hepatic veins were suture ligated as they entered the inferior vena cava. After the specimen was removed a complete hemostasis was insured, and the cut surface of the liver was covered with omentum. The abdomen was drained with cigarette drains and a sump drain placed close to the line of resection.

Dr. Joseph Sherrick: We received a large piece of liver which measured 24 x 20 x 16 cm., and resembled the right lobe of the liver. In Figure 1, one can see the cut surface, which consists mostly of a huge mass of yellowish-gray tumor, projecting to the capsule in several places. There appears to be a margin of relatively normal liver around the tumor. Microscopically, (Fig. 2) the tumor is an adenocarcinoma composed of tall columnar epithelial cells forming irregular glands. Globules of mucin are present in some of the tumor cells. The morphological features of the tumor are consistent with a metastasis from a primary carcinoma of the colon, such as this patient had five years ago.

Dr. Poticha: The first successful left hepatectomy was performed by Keen in 1899. In 1949, Wangensteen performed the first right hepatic lobectomy for carcinoma. Since 1950, many patients with primary malignant tumors of the liver have been cured by hepatic lobectomy. Unfortunately metastatic carcinoma is the most common malignancy found in the liver, and in this disease the results of resection have been encouraging.

In Pack's series of 28 liver resections only one patient with metastatic disease was cured. Although individual cases of metastatic carcinoma cured by liver resection have been reported, the most successful series was reported by Dillard in 1969. Of eight hepatic resections performed for metastatic disease, two patients were alive and well longer than five years after resection, three patients were alive and well from one to five years after resection, and three patients had died of recurrent tumor.

Since it has been possible to cure patients with metastatic disease to the liver by hepatic resection, the operation must be considered in certain well-selected cases. The following criteria must be strictly adhered to when contemplating liver resection for metastatic disease: 1) The primary disease must be controlled or controllable. 2) The metastasis must be confined to one anatomic segment of the liver and must not invade vital structures, such as the inferior vena cava, which cannot be resected. 3) There should be no distant metastasis or other metastasis within the abdomen. 4) The patient must be strong enough to tolerate this formidable operation, and must exhibit sufficient hepatic function. Patients with a BSP greater than 35%, a serum albumin level less than 2.5 gm/100 cc, or an elevated prothrombin time which does not respond to parenteral vitamin K, will not tolerate hepatic lobectomy. Because our patient seemed to satisfy all these criteria the operation was performed.

Postoperatively certain metabolic disturbances commonly occur in patients who have had large portions of their livers removed. These must be anticipated and prevented.

The removal of glycogen stores contributes to the profound hypoglycemia which occurs postoperatively. The infusion of hypertonic solutions of glucose or fructose prevents this complication. This patient received daily intravenous infusions of 10% glucose solution through a centrally placed catheter.

Hypoproteinemia develops rapidly and must be prevented by the intravenous infusion of albumin. This should be continued for about two weeks post-operatively until the liver regenerates enough to produce adequate amounts of endogenous albumin. This patient received 50 gms. of albumin intravenously daily. Despite this therapy his serum protein dropped from a preoperative value of 7.2 gms/100 cc and this level slowly increased after intravenous albumin therapy was discontinued.

Since both protein and fat metabolism is impaired, parenteral vitamins must be supplied. Both fat soluble and water soluble vitamins are required. Cortisone appears to improve liver regeneration in experimental resections, and this patient received 25 mgm of hydrocortisone daily for two weeks.

Dr. Abram Cannon: A liver scan was performed by Dr. James Quinn. This scan was performed using technetium—99 m sulfide, which is deposited in the reticuloendothelial system. The anterior projection demonstrated the defect most effectively in this patient. There appeared to be a filling defect in the inferior portion of the right lobe of the liver. The left lobe of the liver was normal and the spleen was also visualized. (Fig. 3).

Dr. John Beal: One needs to have a realistic attitude about liver resection for metastatic carcinoma. A number of years ago I was involved in the care of several patients who had carcinoma that appeared to be confined to the left lobe. There were five patients in this group who were subjected to left hepatic lobectomy and all developed tumor in the right lobe later. Although these patients obviously had residual tumor at the time of resection, it was not detected. Recently, a 42-year-old woman was admitted to our service with a right nephrectomy for carcinoma of the kidney performed five years earlier. She was well until a year and a half ago when she developed abdominal distress and was found to have a metastasis in the right lobe of the liver. She was subjected to a right hepatic lobectomy after the liver scan had indicated that the disease was confined to the right lobe. She was well until about six weeks ago when she developed symptoms similar to those she had a year and a half ago. She was found to have metastatic disease in the remaining portion of the liver.

These remarks are not presented to discourage resection of the liver for metastatic disease but rather to emphasize the need for careful selection. The operation is formidable and the criteria that Dr. Poticha mentioned should be followed.

Dr. Poticha: Bengemark has pointed out that only 25% of untreated patients with metastatic liver disease are alive six months after diagnosis, whereas 70% of patients who undergo resection survive longer than six months. Despite these interesting statistics I do not believe an operation of this magnitude should be performed as a palliative procedure. Liver resections can only be accomplished with an acceptable mortality rate when the operation is reserved for those patients who fit the criteria outlined and have a chance of permanent cure of their disease. ◄

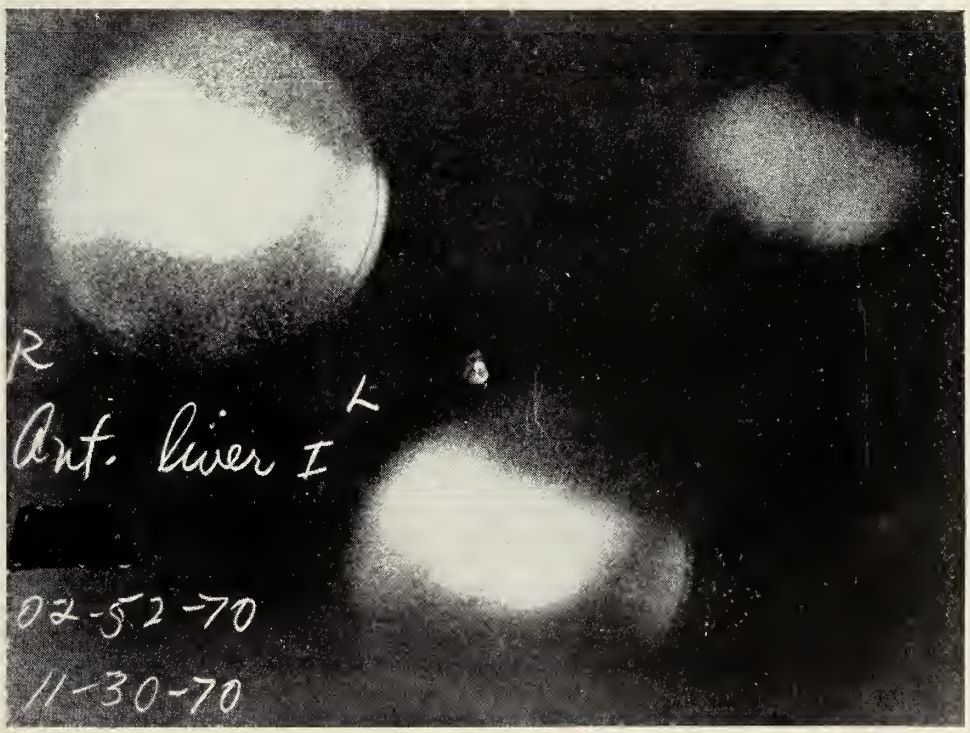
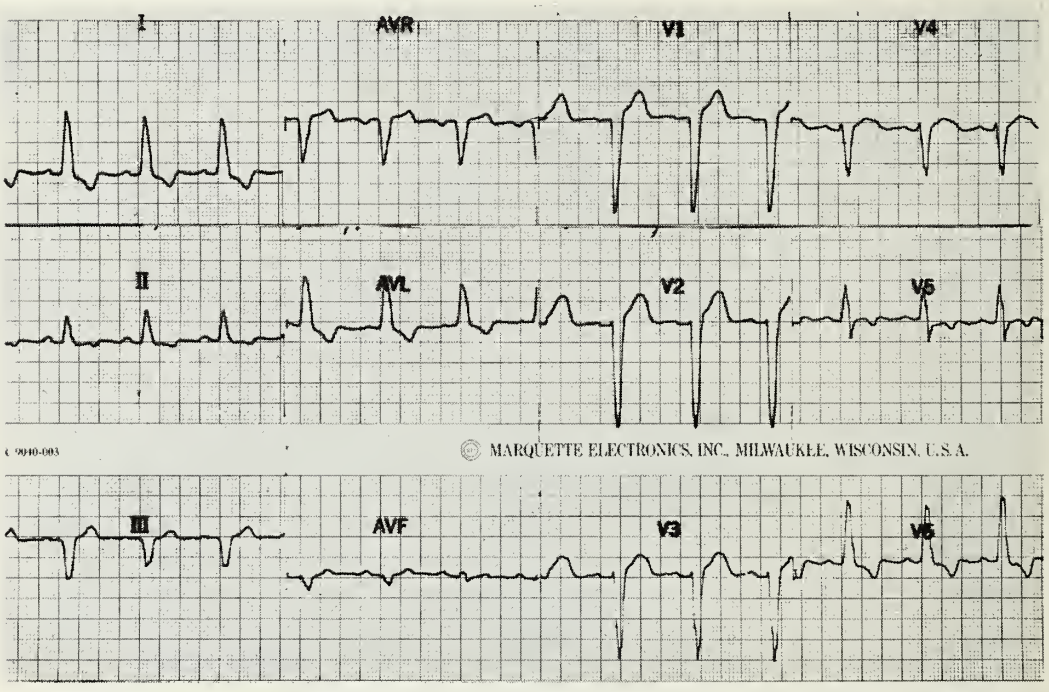


Fig 3. Liver scan demonstrated filling defect in right lobe of liver.

ekg of the month

John R. Tobin, Jr., M.D., M.S., Rimgaudas Nemickas, M.D.
and Patrick Scanlon, M.D./Section of Cardiology,
Department of Medicine
Loyola University Stritch School of Medicine



A 48-year-old housewife was seen for an annual physical examination. She was asymptomatic.

Questions: (One or more of the choices may be correct)

A. The electrocardiogram shows:
 1. Pre-excitation syndrome (Wolff-Parkinson-White)
 2. Right bundle branch, complete.
 3. Left bundle branch block, complete.
 4. LVH with ST-T changes ("strain")
 5. None of the above.

B. The probable clinical conclusions can be made:
 1. The patient may have had diphtheria as a child.
 2. The second heart sound (S_2) showed reversed splitting.
 3. Patient has no impairment of exercise tolerance.
 4. The prognosis for normal life expectancy is good.
 5. All of the above.

(Answer on page 616)

By James P. Paulissen, M.D., M.P.H. and Mary Zeldes, M.D./Springfield

PKU program in Illinois

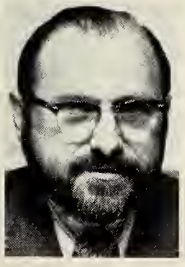
A 10 year study

THE PKU PROGRAM of the Illinois Department of Public Health celebrates its tenth anniversary this year. This report is a study of the statistical material accumulated during these past ten years. A brief history of the program development and a number of categories from the Registry will be reviewed.

In April, 1961, the Governor of Illinois received a letter from a mother of seven children asking for assistance in supplying Lofenalac® to one of her children whom she had diagnosed as having PKU after reading an article on the subject in a lay magazine. With this letter, the official State PKU program was launched in Illinois. During the ensuing ten years, 161 cases have been entered in the PKU registry and have received the dietary product from the State. At the present time, 66 cases remain on the active list and are still receiving dietary treatment.

Prior to the initiation of the official State program, PKU patients had been diagnosed and treated by private physicians, in clinics, and in research centers. The first of these cases was entered on the official PKU Registry on May 11, 1961. Since that time and long before either voluntary or compulsory testing of newborns was legislated, the Illinois Department of Public Health has provided the treatment product, Lofenalac®, at no cost to the families involved.

The Illinois PKU program went through many phases in its development. The first year was devoted to educational programs, counseling services, and case-finding activities. In August, 1962, a document entitled, "Information for Hospital Personnel Regarding the Problems of Phenylketonuria" was prepared by the Bureau of Maternal and Child Health, and was distributed to every hospital in the State.



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MARY ZELDES, M.D., (right) is a consultant pediatrician for the Illinois Department of Public Health, and chief of the Illinois PKU Program. She received her M.D. degree from the University of Illinois Medical School and is a Fellow of the American Academy of Pediatrics and Board member of the American Board of Pediatrics.



PKU program in Illinois

The first PKU Screening Bill, "An Act Concerning the Voluntary Testing of Newborn Infants," was passed in August, 1963. In this bill, the Illinois Department of Public Health was given the responsibility for implementing a program including education, screening and diagnostic tests, maintenance of a registry of cases, providing necessary treatment products, and establishment of an Advisory Committee on Phenylketonuria with a designated membership. Its first concern was the establishment of laboratories qualified for performing PKU screening tests on blood specimens. In August, 1964, with the cooperation of the Illinois Hospital Association, a survey was made of the laboratory facilities of every hospital in the State. This study revealed that approximately 40% of all hospital laboratories were doing their own routine blood screening tests for PKU; the remaining hospitals were using either State or private laboratories for testing or were not routinely testing all newborns.

In April, 1965, two years after the Voluntary Testing Program was initiated, a bill was signed into law making PKU testing mandatory for all newborn infants in Illinois. Again, the Illinois Department of Public Health was given the responsibility to promulgate and enforce rules and regulations for implementing the PKU program. In April, 1966, the officially approved Rules and Regulations for PKU Screening of Newborns, were distributed to all hospitals, physicians, public health agencies, and other interested persons in Illinois.

One of the early problems in setting up a statewide PKU program was to insure adequate facilities for qualified testing of the blood phenylalanine of newborn infants. A survey of hospital facilities for testing was made following the Voluntary PKU act of 1963, and later the State laboratory instituted a procedure for certification of qualified laboratories. In addition, the State Laboratory in Chicago and its two downstate branches performed screening tests for those hospitals whose laboratories were not equipped for testing. Since July 1970, however, the State laboratories have discontinued routine screening tests for hospitals, although the certification procedure for qualifying hospitals for testing continues to be a function of the State Laboratory in Chicago. There are 215 hospitals with maternity services in Illinois, 45 in Chicago and 170 elsewhere in the state. In Chicago, approximately 84% of hospital laboratories are certified for PKU testing, in the remainder of the state 86 hospitals or approximately 50% are so qualified. In addition, seven private laboratories in Illinois and ten out-of-state laboratories are certified for PKU testing (Table 1).

Table 1
Laboratories Approved for PKU Testing
(215 Hospitals with Maternity Services)

	Total Number	Certified for Screening Tests	Certified for Quantitative Tests	Total %
Chicago Hospital Laboratories	45	27 (60.0%)	11 (24.4%)	84.4%
Hospitals in Remainder of State	170	70 (41.1%)	16 (9.4%)	50.5%
Illinois Private Laboratories		7 certified for testing		
Out of State Laboratories		10 certified for testing		

Since 1966, over 96% of all newborn infants in Illinois have received screening blood PKU tests within the first days of life. The small percentage not tested is made up of those infants who died within 24-hours after birth, who were too ill or too premature to be tested immediately after birth, or who moved out of state before they could be tested. Five years ago, prior to the implementation of the compulsory PKU legislation, only about 60% of newborns were screened for PKU. It is interesting to note that during the past ten years there has never been a false negative PKU test reported. Almost 1,000,000 PKU screening tests have been performed since the beginning of 1966, the year that compulsory testing was implemented.

Table 2
PKU Registry
Age When Placed on Registry

Year	Total No. of Cases	Birth-3 mo.	3 mo.-1 yr.	1 yr.-3 yrs.	3 yrs. over	No. of cases still on diet
1961	29	1	1	11	16	2
1962	18	3	3	5	7	2
1963	11	5	3	2	1	2
1964	15	4	5	4	2	2
1965	17	11	0	5	1	6
1966	10	7	0	3	0	5
1967	20	15	2	1	2	14
1968	15	15	0	0	0	13
1969	10	7	0	0	3	5
1970	16	15	0	0	1	15

A summary of the PKU Registry for the past ten years is shown in Table 2. This includes the total number of cases registered each year, divided into groups according to age when placed on the Registry, and number of cases still remaining active and on dietary treatment.

The large number of cases that were placed on the Registry in 1961 and 1962 were cases that had accumulated before the Department instituted the PKU program. These cases for the most part had already been diagnosed and were under treatment when the information was forwarded to the Department with a request that the dietary product be furnished to the families. It will be noted that as the years progressed, more infants were diagnosed and placed on the Registry at an earlier age as the knowledge and testing facilities improved each successive year.

A further study of the 161 cases placed on the Registry in the past ten years, revealed that 135 families were involved. Of these, 116 families (85.9%) had one child afflicted with PKU, 14 families (10.4%) had two children so diagnosed, and five families (3.7%) had more than two PKU children. Two of the 161 patients were Negroes. The sex distribution showed 86 male and 75 female cases (Table 3). Although the sex distribution in our cases follows the expected ratio of male to female births in general and is not statistically significant, Hsia[1,2] has reported that out of a series of 90 PKU infants 60 were male and 30 were female. He later accumulated data showing that 664 males compared to 519 females were diagnosed as PKU.

Table 3

PKU Families and Siblings (161 cases=135 families)

Families	Number of Cases	Percentage
With one PKU child	116	85.9
With two PKU children	14	10.4
With more than two PKU children	5	3.7
Sex of PKU Infants		
Male	86	53.4
Female	75	46.6

The date of birth of the 161 registered cases was analyzed to see if there was a seasonal predilection for this inherited disease. It was found that more infants were born with PKU in the winter and summer months (approximately 58%) than in the spring and fall months (approximately 42%) (Table 4). Although this difference does appear to be statistically significant, it loses this significance when related to the variation of numbers of live births by season.

Table 4

Seasonal Incidence of PKU Births

Season	Month	No. of PKU Births	Seasonal Total PKU Births
Winter			46
	December	16	
	January	16	
	February	14	
Spring			32
	March	10	
	April	8	
	May	14	
Summer			47
	June	17	
	July	12	
	August	18	
Fall			36
	September	12	
	October	14	
	November	10	

Of all the information gathered from this 10 year summary, the educational progress of the patient was considered to be a practical overall estimate of the child's level of function. The child's educational classification was ascertained since this is generally considered the measure of functional achievement in children. The progress of 90 children registered between 1961 through 1965 was studied because these children were of chronological school age; those registered after 1965 were in most instances too young for formal education. The children were classified according to age that treatment was initiated into the following four divisions: birth to three months of age; three months to one year; one year to three years; and over three years at onset of treatment. The educational progress was also divided into categories, as follows: severe retardation so that the children were either in an institution or were uneducable at all; the trainable mentally handicapped and the educable mentally handicapped who were in special education classrooms, those who attended regular classes in regular schools; those whose progress was unknown; those who turned out to be not true PKU cases; and one infant who died shortly after birth. As shown in Table 5 there seems to be no definite predictable relationship between age of starting treatment and level of educational attainment. However, a few items are worthy of comment:

- of the 24 children who were placed on dietary therapy prior to three months of age, 14 (58%) were able to attend regular school; only one child started in this age group showed severe retardation.
- of the 51 children placed on dietary therapy after one year of age, 16 (31%) achieved educable status; eight (16%) were in regular

school and 10 (20%) are severely retarded.

- of the 14 children who were severely retarded, 10 (71%) were not started on therapy until after one year of age.
- of the 12 children who were trainable mentally handicapped, none was started on treatment under three months of age, and 10 (83%) were started after one year of age.
- of the 26 children who were able to attend regular classes at regular school, over half of the children (14) were started on treatment prior to three months of age. None in this category were started after three years of age, however eight (31%) were started between one and three years of age.

A study of the above statistics seemed to confirm the findings of other studies which showed that the earlier treatment was instituted, the better the chance for increased educability and mental progress.[3-6]

Table 5
Educability According to Age At Start of Treatment

	Birth to 3 m.	3 mo. to 1 yr.	1 yr. to 3 yr.	over 3 yr.	Totals
Severe Retardation	1	3	8	2	14
Trainable	0	2	6	4	12
Educable	5	4	14	2	25
Regular School	14	4	8	0	26
Progress Unknown	1	1	1	5	8
Not True PKU	2	1	1	0	4
Other (died)	1	0	0	0	1
TOTALS	24	15	38	13	90

The incidence of PKU in Illinois has varied from year to year. Using the data accumulated since compulsory testing was initiated in 1966, the ratio of PKU cases to live births was approximately 1:28,000 in 1966, 1:13,600 in 1967, 1:12,700 in 1968, 1:27,000 in 1969, and 1:15,000 in 1970. The over-all ratio for the five years was 1:17,598 (Table 6). The literature is replete with controversial figures on the incidence of PKU in newborn infants. The difficulty lies in the interpretation of the laboratory data in regard to the exact diagnosis of the various forms of excessive phenylalanine determinations. Our figure of 1:17,598, however, is in keeping with some of the more recent reports[7,8] which show an incidence of from 1:19,500 to 1:13,000.

Table 6
Incidence of PKU in Illinois (Screened at Birth)

Year	Number of Live Births	PKU Cases	Ratio
1966	196,562	7	1:28,080
1967	190,938	14	1:13,638
1968	188,469	14	1:12,747
1969	191,317	7	1:27,331
1970	200,664	13	1:15,435
	967,950	55	1:17,598

The accumulation of 161 cases of a disease as rare as PKU offers an unusual opportunity to increase the understanding of the disease and its variants. This recorded data not only enhances medical knowledge but also benefits the patient and his chances for improved mentality. The clinical findings based on this statistical report will be presented by the consultants to the program at a later date. ◄

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By Stuart M. Poticha, M.D./Chicago

Treatment of penetrating wounds of the liver in Viet Nam

ALTHOUGH A STATISTICAL ANALYSIS of the casualties in the Viet Nam War has yet to be prepared, most military and civilian consultants have reported a change in the incidence, nature and treatment of wounds of the liver.

Studies of the casualties occurring in World War II revealed that liver injury occurred in 10 to 27% of abdominal wounds. The vast majority of these wounds consisted of simple lacerations of the liver parenchyma. Patients with massive liver injuries often died before they reached the hospital. In World War II, the average time between wounding and operation was 10.5 hours for patients with abdominal wounds.[1] During the Korean War, this time lag was reduced to 6.3 hours.[2]

Most of the casualties in Viet Nam are evacuated by helicopter, resulting in a further reduction in time to 2.8 hours.[3] Furthermore, patients with severe wounds who are in deep shock frequently bypass the clearing station and are brought directly to a surgical or evacuation hospital. Because of the distribution of hospitals in Viet Nam and the wide use of helicopter evacuation, wounded soldiers are rarely more than 20 minutes from a well equipped surgical facility. In many instances, a fully resuscitated patient is brought to the operating room less than an hour after wounding. As a result, many of the injuries encountered revealed maceration, extensive stellate lacerations or hilar wounds of the liver, with massive uncontrolled hemorrhage. As General Thomas J. Whelan, Surgical Consultant, U.S. Army, Pacific, commented, *"it is probable that the magnitude of liver injuries seen in the operating room in Viet Nam was usually seen in morgues in previous wars."*[3]

In addition to the rapid evacuation of casualties, the high incidence of severe liver wounds is further explained by a change in the ballistics of the rifles used in Viet Nam. Although many factors influence the wounding capability of a bullet, in a solid organ, tissue damage is directly proportional to the energy imparted by the penetrating missle. The kinetic energy of a bullet is increased by the square of its muzzle velocity.[4] The AK-47 rifle used by the enemy in Viet Nam has a high muzzle velocity of 3200 ft./sec., roughly 30% higher than the muzzle velocity of the M-1 rifle used during World War II. These high velocity missiles cause massive destruction of liver parenchyma with extensive lateral fissuring (Figs. 1, 2 & 3).

The experience gained treating extensive liver injuries secondary to blunt trauma[5-6] has led to a more aggressive approach now being used in the management of liver injuries in Viet Nam. Current treatment is based on strict adherence to four surgical principles: (1) control of hemorrhage; (2) adequate external drainage; (3) internal biliary decompression; and (4) resection of all devitalized tissues.



Fig. 1a. High velocity bullet wound causing maceration of the posterior segments of the right lobe of the liver.



Fig. 1b. Posterior segmentectomy of the right lobe of the liver, through a thoracoabdominal incision. From ADVANCES IN SURGERY, Volume 3 Edited by Claude E. Welch. Copyright 1968. Used with permission.

In Madding's review of liver injuries in World War II, active hemorrhage was observed at operation in only nine per cent of the cases.[7] In Viet Nam, the incidence appears to be higher. In most instances, hemostasis can be achieved by suture ligation of individual bleeding vessels. Bleeding from broad liver surfaces is controlled by placing absorbable mattress sutures close to the cut edge so as not to devitalize the remaining liver tissue. Hemostatic agents such as Gelfoam or Surgicel may be applied temporarily but they should be removed before closing the abdomen. These foreign bodies serve as a medium for infection. Nonabsorbable packs are not used for they lead to infection and abscess formation, or secondary hemorrhage when the pack is removed. Packing has not been used since World War I, when it was found that the use of packs was as-



Fig. 2. High velocity bullet wound causing stellate laceration of the anterior inferior segment of the right lobe of the liver. Mattress sutures (arrow) are placed prior to excising injured segment.

deep lacerations occur, the Penrose drain can be placed within the liver parenchyma after hemostasis is achieved. With extensive destruction of liver tissue, sump drains may be used to drain the subphrenic space.

The addition of biliary tract decompression to the treatment of liver wounds was suggested by Merendino in 1963.[10] He reasoned that, in the valveless biliary system, bile would travel in the direction of least resistance. With a contracted sphincter of Oddi, this might well be through the cut biliary ducts in the liver wound. A T-tube was placed in the common bile duct when a deep laceration in the liver parenchyma was present or when lobectomy or segmentectomy was performed.

Resection of all devitalized

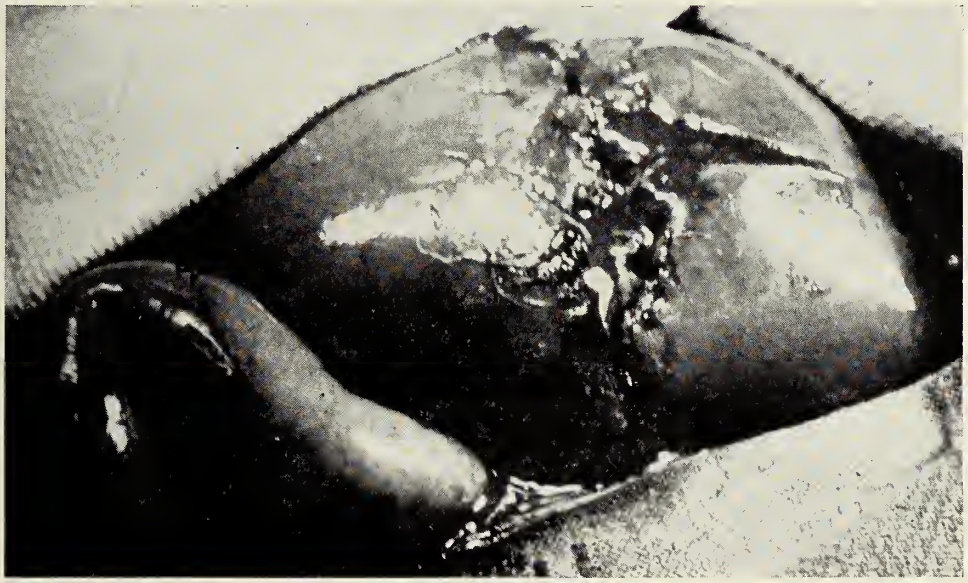


Fig. 3. Stellate laceration of the right lobe of the liver. Bluish discoloration of the anterior inferior segment (arrow) indicated interruption of its blood supply necessitating segmentectomy. From ADVANCES IN SURGERY, Volume 3, Edited by Claude E. Welch. Copyright 1968. Used with permission.

sociated with a mortality rate of 66%,[8] the same as that reported by Elder in 1887 using nonoperative treatment.[9]

External drainage is used in all liver injuries. Drains provide a means of egress for bile which leaks from the lacerated liver surfaces. In addition, they may help to prevent subsequent abscess formation about the liver. Penrose drains are liberally placed about the laceration. When

liver tissue is essential in the management of these wounds. Segmentectomy or lobectomy was required when maceration of the liver parenchyma was present (Fig. 1). In addition, large stellate lacerations occasionally devitalized a segment or lobe by interrupting its blood supply. (Figs. 2 & 3). Clearly, a complete knowledge of the intrahepatic anatomy is essential in planning these resections.



Fig. 4. Deep tunneled tract wound of the right lobe of the liver without hemorrhage or devitalization of liver tissue. Treatment consisted of external drainage and biliary decompression.

The liver wounds encountered in Viet Nam could be divided into one or more of three categories: (1) simple lacerations; (2) tunneled tract wounds; and (3) maceration of the liver with stellate lacerations.

Simple lacerations occurred most frequently. These puncture wounds or linear cracks along the hepatic surface usually did not present serious problems in management. Most often, bleeding ceased spontaneously and only liberal external drainage with Penrose drains was required. Bleeding, when present, was controlled by suture ligation of the torn vessels. Deep lacerations were never closed for this predisposed to subsequent intrahepatic abscess or hemobilia. The biliary system was decompressed by T-tube drainage of the common duct, whenever deep lacerations were encountered.

Tunneled tract wounds occurred when a missile penetrated the liver parenchyma, traveled for some distance within the liver and then exited. When these injuries were encountered without serious bleeding, they were treated with external drainage. Biliary decompression was added when deep tracts were found near the hilum of the liver (Fig. 4). When persistent bleeding was present, superficial tracts were unroofed and the bleeding vessels identified and suture ligated. However, deep tracts could not be unroofed without devitalizing large areas of the liver. These injuries were treated by resection of the involved segment. On one occasion, we encountered massive bleeding from a deep tract which extended through both lobes of the liver. This patient was managed by completely filling the tract with a long strip of autogenous rectus muscle (Fig. 5). The entrance and exit wounds in the liver were drained and the biliary system was decompressed. This patient made an uneventful recovery.[11]

Maceration of the liver or stellate lacerations occurred with high velocity missile injuries (Figs. 1, 3, & 4). These wounds invariably required hepatic segmentectomy, or lobectomy. Segmentectomy was usually performed through a midline abdominal incision. Lobectomy and rarely segmentectomy (Fig. 2) required extension of the incision into the chest. A thoracoabdominal incision provided better exposure and allowed the surgeon to control the suprahepatic inferior vena cava to prevent air embolus from the large hepatic veins. Bleeding was controlled during the resection by temporary occlusion of the hepatic inflow through the foramen of Winslow. Following resection, the raw liver surface was drained externally and the biliary tract was decompressed.

The technology of modern warfare has changed so that more patients with severe liver injuries arrive at the hospital alive. The basic surgical concepts and techniques outlined here are presently being used in Viet Nam to successfully manage many of these massive liver injuries. ◄

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Fig. 5. Deep tunneled tract wound of both lobes of the liver with hemorrhage. Treated by filling the tract with a strip of autogenous rectus muscle, external drainage and biliary decompression. Muscle can be seen protruding from the exit wound in the right lobe of the liver (arrow). From MILITARY MEDICINE, Volume 134, No. 4, April, 1969, p. 285. Used with permission.

Caduceus

"And the Lord sent fiery serpents among the people, and they bit the people; and much people of Israel died.

Therefore the people came to Moses, and said, We have sinned, for we have spoken against the Lord, and against thee; pray unto the Lord, that He take away the serpents from us. And Moses prayed for the people.

And the Lord said unto Moses, Make thee a fiery serpent, and set it upon a pole: and it shall come to pass, that every one that is bitten, when he looketh upon it, shall live.

And Moses made a serpent of brass, and put it upon a pole, and it came to pass, that if a serpent had bitten any man, when he beheld the serpent of brass, he lived." (Chapter 21, Verses 6-9. **The Fourth Book of Moses, Called Numbers.**)

HASP HASP HASP HASP HASP

The Hospital Admission and Surveillance Program will directly affect every physician who treats public aid recipients. Here's how it will work. . . .

THE ILLINOIS FOUNDATION for Medical Care unveils its first program next January 15, when HASP—Hospital Admission and Surveillance Program—becomes effective in seven large Chicago hospitals.

IFMC developed HASP to help save the state's faltering Medicaid program an estimated $25 million annually.

Under HASP, every Medicaid hospital admission will be certified for length of stay. This will be determined from the Professional Activities Study (PAS) for Illinois. HASP committees will also monitor the activities of hospital utilization review committees.

The HASP contract calls for beginning the program by Jan. 15, in those hospitals having 1,000 or more Medicaid hospital days in September, 1971, and those with residency training programs in medicine and surgery.

By December, 1972 HASP must be operational in 85% of the state's hospitals and skilled and intermediate care nursing homes.

Since HASP will directly affect every physician who treats public aid recipients, a detailed explanation of how the program will be structured and operated follows:

The structure of HASP

The IFMC will establish a state HASP Committee to establish policy and oversee the affairs of the program. This committee will be composed of four physicians—appointed by the IFMC Board of Directors—two hospitals members (one appointed by the Board of Illinois Hospital Association, and the other by the Board of Chicago Hospital Council), and one consumer appointed by the Illinois Department of Public Health Director. The senior administrative officer of HASP is the IFMC's Executive Vice-President. His responsibilities include appointing a state project director for HASP who will be directly responsible for the statewide program.

The composition of the state HASP Committee will be duplicated at the regional and local levels. Each region, as designated by Governor Ogilvie's executive order on regionalization, will have a regional HASP comittee and director.

Committee responsibilities

The responsibilities of the state HASP Committee include making all administrative and

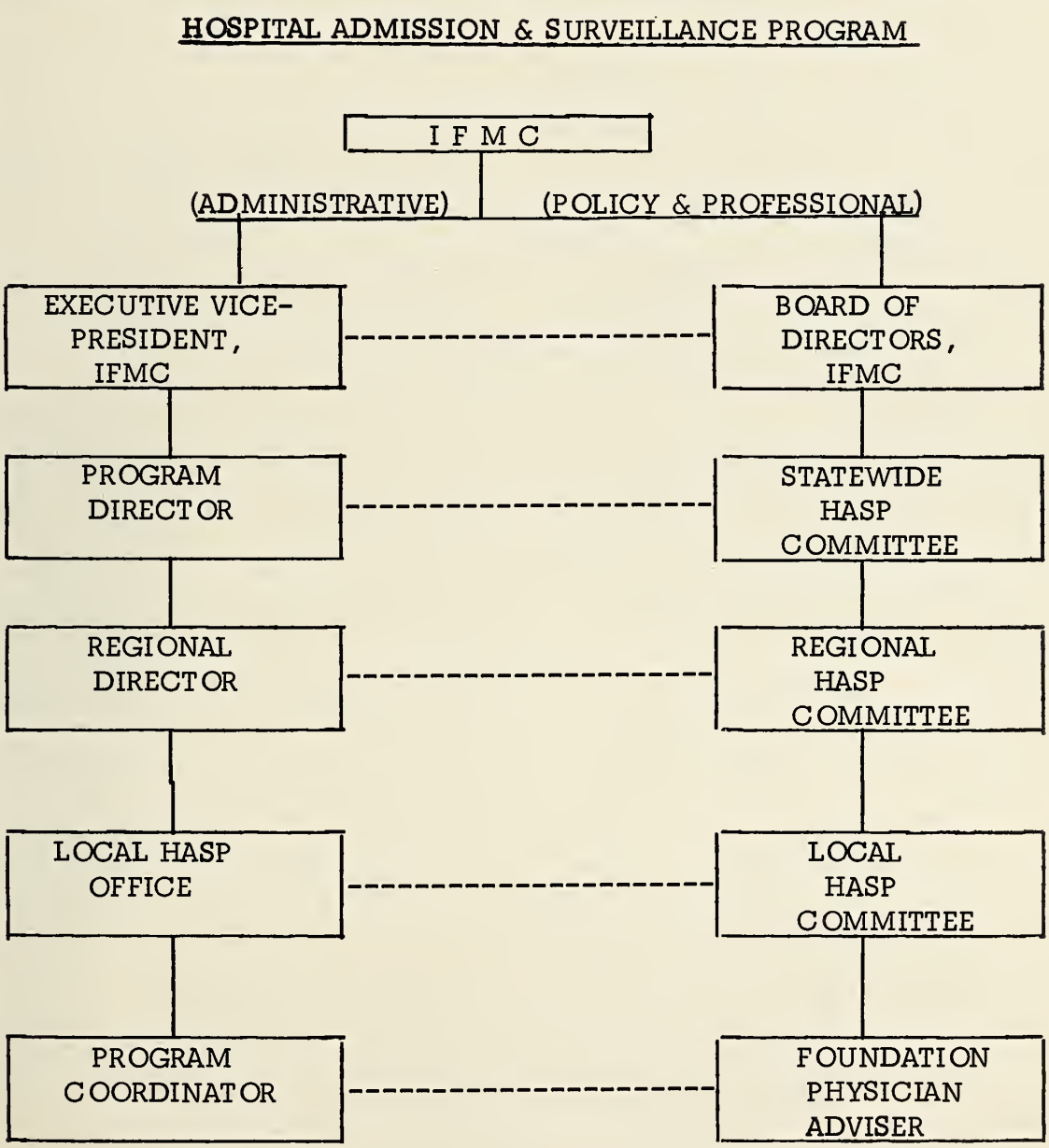
policy decisions and approving the appointment of all regional administrators.

Regional HASP Committees will be responsible for making rules and regulations not expressly prohibited by the state HASP Committee. The regional committees will also be responsible for all policy and HASP medical decisions within their areas, and serve as advisors to the regional administrator in their areas.

Local HASP Committees will nominate a physician advisor to the Regional HASP Committee. The local groups will also advise regional HASP on changes in standards and criteria for local needs, and serve as courts of first appeal for grievances. The local committees will monitor the activities of the local physician advisors and actively participate in monitoring the local hospital utilization review committees.

All hospitals in the state will be assigned program coordinators who will give length of stays to each Medicaid hospital admission. These coordinators, or clerks, will use the physician's diagnosis as the basis for the length of stay.

The state HASP Committee will approve all length of stay standards. At the start, the program will use PAS (Professional Activities Study) Illinois statistics as the base point for developing admission and length of stay criteria. These statistics will determine length of stays for 183



diagnostic groups and 177 operative procedures.

HASP's initial certification for length of stay will not exceed the 50th percentile. As the program gains experience, this may be modified.

How HASP works

The responsible physician must authorize the hospital admission. On all elective admissions, (any procedure considered by the responsible physician to be non-acute or non-emergent), certification will be given at the time of admission.

Before he wishes to admit his patient, the physician will be asked to complete a certification request form on which the diagnosis is stated. This form is submitted to the hospital program coordinator who assigns the appropriate number of days for which payment will be allowed. The program coordinator's assignment of days is based upon the physician's diagnosis.

This certification will be recorded with the approved number of days on the patient's chart and a copy forwarded to the HASP Regional office. In the event of difficulty in determining the length of stay, the physician advisor in the hospital can be called upon. The physician advisor must be consulted on all decisions requiring professional judgement.

If the attending physician decides an extension of stay is medically necessary, he obtains such certification through the HASP office. Whereever possible, the attending physician will be informed two days before his patient is due for discharge on the expiration of the initial certified date for discharge. This advance notice enables him to request an extension if he feels one is necessary.

Emergencies and acute procedures, of course, preclude assignment of length of stay prior to hospitalization. Such assignment should be made, however, within one working day after the admission.

HASP's role in the long-term care program

HASP also has the responsibility for the certification of continued stay every 30 days for skilled care nursing homes, and every 90 days for intermediate care facilities. HASP is responsible for designating the level of care required in the nursing homes. This certification will be done by the patient's physician. HASP will appoint physicians to participate in the medical review process of the Illinois Department of Public Health as required by the Medicaid program. These physicians will be paid for their service by IDPH.

Utilization Review Committee Program

In addition to its hospital surveillance duties, the Regional HASP Committee will also be responsible for monitoring the activities of all hospital utilization review committees within the region. This monitoring function will follow previously established standards, structures, procedures and activities of utilization review committees set down by the Department of HEW.

Other services that will be conducted under this phase of HASP will be:

- education and training of hospital UR committees
- provision of sample surveys for evaluation by UR committees
- evaluation of Extended Care Facilities
- the monitoring of and follow-up implementation of UR committee recommendations made to hospital administrators and medical staffs
- certification evaluation of hospital UR committees to be forwarded to the Illinois Department of Public Health for Medicare and Medicaid

If the Regional HASP Committee determines that a hospital UR committee is in substantial non-compliance with federal regulations, it will recommend that IDPH take necessary action to remove that facility from participation in the Medicare and Medicaid programs.

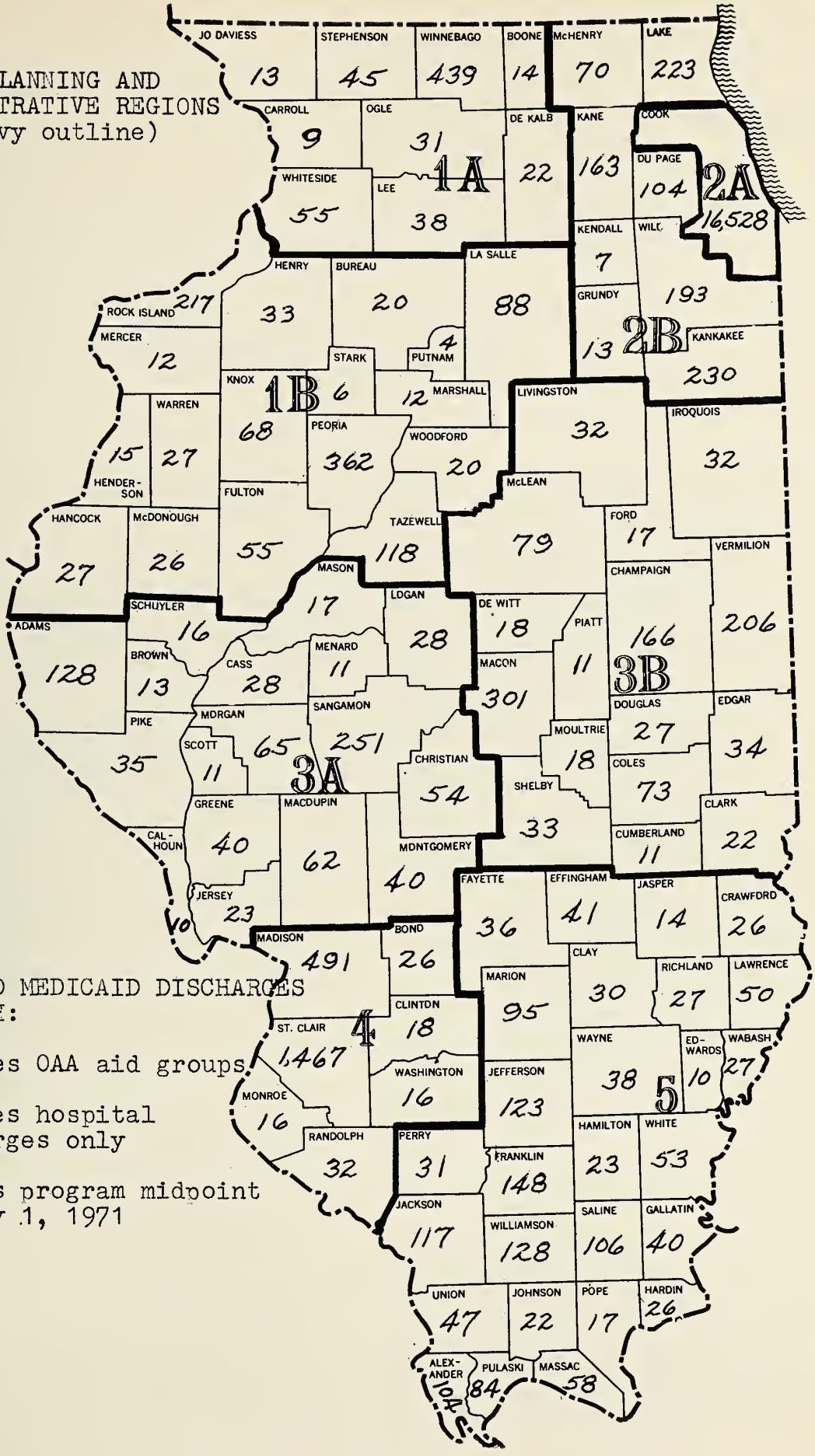
Procedural elements of HASP

The Illinois Department of Public Aid remains the actual fiscal agent and will only pay claims for services that any participating provider renders to an eligible beneficiary hospitalized as an in-patient, which are properly certified approved by the HASP Committee, or its authorized agents.

In cases of non-compliance with standards or procedures, the HASP State committee may assume area functions directly, and may request the IDPH Director to assist in correcting non-compliance in any region or sub-region.

Fiscal

According to the HASP contract, the state will pay IFMC up to $15 for each Medicaid hospital certification of admission, and up to $3 per admission for the utilization review function.


STATE PLANNING AND ADMINISTRATIVE REGIONS (heavy outline)
ESTIMATED MEDICAID DISCHARGES PER MONTH:
..Excludes OAA aid groups
..Includes hospital discharges only
..Assumes program midpoint of July 1, 1971
JO DAVIESS 13
STEPHENSON 45
WINNEBAGO 439
BOONE 14
McHENRY 70
LAKE 223
CARROLL 9
OGLE 31
DE KALB 22
KANE 163
COOK 16,528
DU PAGE 104
WHITESIDE 55
LEE 38
1A
2A
KENDALL 7
WILL 193
HENRY 33
BUREAU 20
LA SALLE 88
GRUNDY 13
2B
KANKAKEE 230
ROCK ISLAND 217
MERCER 12
STARK 4
PUTNAM 12
MARSHALL 6
KNOX 68
1B
WARREN 27
HENDER-SON 15
PEORIA 362
WOODFORD 20
LIVINGSTON 32
IROQUOIS 32
FULTON 55
TAZEWELL 118
McLEAN 79
FORD 17
HANCOCK 27
McDONOUGH 26
MASON 17
SCHUYLER 16
LOGAN 28
DE WITT 18
PIATT 11
CHAMPAIGN 166
VERMILION 206
ADAMS 128
BROWN 13
CASS 28
MENARD 11
MACON 301
3B
PIKE 35
MORGAN 65
SANGAMON 251
DOUGLAS 27
EDGAR 34
SCOTT 11
3A
CHRISTIAN 54
MOULTRIE 18
COLES 73
SHELBY 33
CLARK 22
GREENE 40
MACOUPIN 62
MONTGOMERY 40
CUMBERLAND 11
CAL-HOUN
JERSEY 23
FAYETTE 36
EFFINGHAM 41
JASPER 14
CRAWFORD 26
MADISON 491
BOND 26
CLAY 30
MARION 95
RICHLAND 27
LAWRENCE 50
CLINTON 18
ST. CLAIR 1,467
4
WAYNE 38
ED-WARDS 10
WABASH 27
WASHINGTON 16
JEFFERSON 123
5
MONROE 16
RANDOLPH 32
PERRY 31
FRANKLIN 148
HAMILTON 23
WHITE 53
JACKSON 117
WILLIAMSON 128
SALINE 106
GALLATIN 40
UNION 47
JOHNSON 22
POPE 17
HARDIN 26
ALEX-ANDER 104
PULASKI 84
MASSAC 58

HASP

Time Schedule

The IFMC through the HASP program will meet the following schedule of events in 1972:

January 15

Admission and Utilization Review Committee programs functioning in those hospitals with more than 1,000 Medicaid hospital days in September, 1971, and having residency training programs in medicine and surgery.

April 15

Admission and Utilization Review Committee programs functioning in at least 75 of the certified hospitals, reasonably balanced throughout the state.

Proposal submitted for utilization review of out-patient services in hospitals.

July 15

Admission and Utilization Review Committee programs functioning in at least 175 hospitals and 300 skilled and intermediate I nursing homes reasonably balanced throughout the state.

December 15

HASP operating in 85% of all hospitals which admit Medicaid patients, and skilled and intermediate I nursing homes. ◄

13 steps to avoid a malpractice suit

Once professional liability insurance has been bought and the policy carefully read, the following steps are recommended when problems arise with a case:

1. **Alert your insurer.** Notify him as soon as an accident occurs, insteading of waiting until you receive notice of an impending lawsuit.

2. **Keep your insurance coverage to yourself.** Do not invite a malpractice suit by announcing to others the extent of your insurance coverage.

3. **Admit an honest mistake—but not legal liability.** Admitting an honest mistake is not the same as assuming liability. A court of law is responsible for determining liability.

4. **When you do err, avoid the risk of making an even bigger error—that of trying to cover up.** Even after making an error, continue to practice good medicine. A court may forgive an honest mistake, but usually will not rule favorably if a mistake is compounded by an effort to cover it up.

For guidance with a specific case, the best initial source of advice is your professional liability insurer.

5. **Refer the plaintiff's attorney to your own.** Allow the lawyers to talk together, with the physician staying out of the conversation as much as possible.

6. **If a case doesn't go quite right, think twice about turning the patient's account over for collection.** Employing a collection agency often is the action which finally pushes a patient into bringing charges against a physician.

Additional suggestions in avoiding a law suit include:

7. **Learn to recognize a suit-prone patient.** Special care should be taken with patients who show an over-concern with money, unusually pointed criticism of one or more previous doctors, suspicion, and an unrealistic expectation of good results.

8. **Proceed only with a patient's informed consent.** A physician cannot legally proceed unless informed consent is obtained from the patient.

9. **Practice within the limits of your competence.** If a physician presents himself as a specialist, he must practice as a competent specialist.

10. **Be slow to guarantee a good result.** If care is taken while discussing a case or procedure with a patient, there is less chance of being held for breach of oral contract.

11. **Keep good records.** Extensive, accurate records are a necessity if a case is brought to court.

12. **See a case through once you start.** Once a physician begins to see a patient, he cannot abandon him without being held responsible for him.

13. **Head off assistant's errors.** The physician is responsible for anything done by anyone who works for him.

Reprinted with permission from the June, 1970 issue of ***Resident and Staff Physician.***

Illinois State Medical Society response To Senate Resolution No. 119

Submitted October 20, 1971

Introduction

ON APRIL 20, 1971, the Illinois State Senate adopted Resolution No. 119 urging the American Medical Association and the Illinois State Medical Society to **"recommend to the General Assembly the best means by which this state can interest physicians to decentralize their practices by making themselves available throughout the state." In other words, how can Illinois solve the physician shortage problem, especially in the urban ghetto and rural areas.**

While our current supply of physicians is drastically low—and is expected to remain that way for the next five to ten years—the outlook for increasing their supply and availability in the 1980's is bright. Our optimism is based on two significant factors:

1. **The decentralization of medical education through the establishment of medical schools in Springfield, Peoria and Rockford.**
2. **Expansion of present medical schools.**

What happens, however, between now and 1981? What can Illinois do to solve the physician-shortage problem in the immediate future?

After six months of intensive study by our leading physicians, who contributed more than 300 man-hours to the project, the **Illinois State Medical Society has concluded that there are no guaranteed solutions to the physician maldistribution problem.** Theories, yes! Constructive ideas based on successful pilot projects, yes! But no *guaranteed solutions!*

Since any system of recruitment must be based on free choice, competition between communities for physician services will always be strong, and young physicians—like all other professional people—seek out viable, growing communities in which to establish practice and raise their families.

Consequently, the so-called "dying" town, abandoned by industry and business, stands little chance of attracting physicians—or lawyers, engineers or teachers for that matter. Rather than trying to find a "physician-in-residence" for those communities, we must consider alternative methods of providing medical services to them.

On the other hand, there are many urban ghettos and rural areas that have all the characteristics of a growing, thriving community, but still cannot attract physicians. We believe that, with the proper guidance of the medical profession and other health professionals, these communities can make themselves attractive to physicians, dentists, nurses and other health personnel. But the job won't be easy.

Who determines whether a community has the potential to attract health personnel? And how is this determined? The recommendations on the following pages will provide the answers to these questions.

NOTE: The Illinois State Medical Society endorses the American Medical Association response to Senate Resolution No. 119. Since its analysis of the health manpower problem is applicable to Illinois—and establishes a general foundation for our report—we suggest that the General Assembly study it carefully before considering the following recommendations.

I. The State of Illinois should establish a Division of Health Manpower Recruitment in the Commission on Business and Economic

Senate Resolution No. 119 response

Development to work with the Illinois State Medical Society in achieving the following objectives:

A. Define the "medically-deprived" areas in Illinois and establish a priority list on which the state would concentrate its efforts of assistance. Information obtained should be stored—and updated periodically—in a data bank for quick reference. It is recommended that the proposed division have physician as well as consumer representation.

B. Provide expert consultation to those communities identified as medically deprived with the objective of helping them attract health personnel. Consultants from the Division of Health Manpower Recruitment would help develop promotional materials on the communities requesting such help and advise them on recruiting tactics. (This would be analogous to the state's economic development program, utilizing the data bank described previously.)

C. Conduct continuing recruitment campaigns to attract out-of-state health manpower to Illinois, using the data bank for information about the community, e.g. churches, schools, banks, industry, medical schools or other education affiliations.

II. The State of Illinois should finance a pilot project providing a two-way closed circuit television set-up between a physician's office or university center and an outlying area health station. If this proves successful, similar TV set-ups could be established throughout the state to deliver initial patient care to medically-deprived areas.

With the help of a physician's assistant or nurse, the physician could hold daily "office hours" with his patients in the nearby town merely by tuning in on his closed-circuit TV set.

III. The State should encourage the Health Education Commission of the Board of Higher Education to include motivational research of health personnel in its new "Rand Study."

To attract young physicians to our rural and ghetto areas, we must learn what motivation factors are effective in persuading them to practice there. Therefore we believe the Health Education Commission should include motivational research of health personnel in its "Rand Study."

IV. The Illinois Department of Registration and Education should be encouraged to notify physician licensure applicants that the Medical Licensure Act requires only one year of hospital training—and does NOT require a rotating internship.

Many physicians have been discouraged from applying for Illinois licensure because they did not have a rotating internship.

V. The State should encourage establishment of innovative medical education programs to interest students in opportunities available in rural areas, ghettos and small towns.

One of the most successful programs of this nature is the Medical Education and Community Orientation (MECO) project in which medical students spend their summer working with physicians in community hospitals. MECO—sponsored by the Student American Medical Association—began in Illinois several years ago and has proved so popular that it is now a national program. Studies show that the project has been instrumental in interesting students in downstate practice.

VI. The State of Illinois should provide full tuition scholarships and reasonable living expenses for qualified medical students who agree to practice in rural, small town or ghetto areas and for those students who are able and capable of attending medical school but who do not have the resources to do so.

This recommendation is prompted by the successful Rural Student Loan Program co-sponsored by ISMS and the Illinois Agricultural Association. Over the past 15 years, the program has helped almost 100 small towns in need of a physician to obtain one. Under the program ISMS-IAA provide low interest loans to medical students in return for their promise to practice in a small town within Illinois.

VII. The State Legislature should continue to provide funds for medical school expansion of clinical clerkships in non-university community hospitals.

VIII. The State of Illinois should encourage the expansion of residency programs throughout the state and provide the financing assistance necessary to accomplish this.

It's an accepted fact that physicians usually establish practice in the area where they serve their residencies. Since virtually all Illinois residency programs are in the Chicago area, residents are not exposed to community hospitals and rural areas. Therefore, it is difficult to "sell" them on downstate Illinois.

In establishing such a "Community Hospital Residency Program," the University of Illinois and its component schools should be encouraged to accept affiliation with more community hospitals. Of course, small hospitals would have to provide an attractive setting for training and practice so that the interest of these doctors in the community would be maintained.

Communities themselves will have the obligation to furnish excellent facilities and there must be constant and continued citizen responsibility for involving the postgraduate student in local activities.

Funding of these residency programs by the state would be necessary as would additional funding for the medical schools. Money is needed to effect a gradual transition to put postgraduate education into more communities. This is a statewide responsibility to meet unmet needs by the medical schools and medical centers. (See Recommendation IX)

IX. The Legislature should try to increase medical manpower as it applies to postgraduate training by implementing the recommendations of the 1969 Report to the Board of Higher Education on Health Education for the Professions, commonly known as "The Campbell Report." The Campbell Report recommendations are as follows:

(Recommendation 33) "Adequate funds should be appropriated to the Health Education Council for the planning and capital expenses necessary for developing postdoctoral programs and an appropriation should be made for operating expenses. The Health Education Council should grant portions of this allocation to appropriate private and public clinical facilities and educational institutions for the actual development and operation of such programs. Grants should be made on the basis of $2,500 per projected enrollee as planning and capital funds, and $2,500 per enrollee as operating funds. Priority should be given for fostering postdoctoral programs through universities and clinical centers having new or expanded enrollment of undergraduate medical students."

(Recommendation 32) "Awards for postdoctoral programs should be planned on the apparent ability of the institution to fill its postdoctoral training positions and should be based on the actual number participating. The Health Education Council should, of course, bear in mind that one of the best recognized factors relating to filling house officer positions (postdoctoral) is affiliation of the program with a medical school or other appropriate, recognized teaching institution. If there were insufficient postdoctoral programs generated by the hospitals themselves throughout the State in response to this opportunity, the Health Education Council could directly undertake to stimulate development of appropriate programs, through the medical schools."

X. Where internship and residency programs abroad are deemed comparable to U.S. residency and internships, the Illinois Department of Registration and Education should be encouraged to allow physicians to substitute that training for the required American internship and residency training.

The World Health Organization directory of medical schools lists many foreign medical schools which have curricula comparable to our American schools. The excellence of these schools is borne out by the high percentage of their graduates who pass the ECFMG examinations. Unfortunately, however, their internship and residency training is not recognized as fulfilling the requirements of the Illinois Department of Registration and Education . . . and they must repeat their internship and residencies if they wish to practice in Illinois. Obviously this discourages qualified physicians from immigrating to Illinois.

XI. The State Legislature could make Illinois more attractive to physicians by improving the malpractice climate through the enactment of proposed legislation. For instance:

A. Place a specific statute of limitations on filing of malpractice suits. The present statute of limitations is two years after discovery. We recommend limiting it to three years *after date of actual injury.*

B. Reduce the statute of limitations for foreign substances negligently left in the body from 10 to five years after treatment.

C. Prohibit the invoking of *res ipsa loquitur* doctrine in malpractice suits.

Senate Resolution No. 119 response

D. Require the plaintiff to verify his pleadings. All pleadings from the original complaint should be sworn to under oath. If the pleadings are sworn to and are proved false, the plaintiff should be charged with perjury.

E. Require the plaintiff in malpractice suits to post a $500 surety bond.

F. Extend the Good Samaritan concept to any emergency situation on the premises of a hospital.

ISMS Task Force on Physician Shortage
And Services to Medically Deprived Areas

William Lees, M.D., *Chairman*

Fred White, M.D.
Arthur Appleyard, D.O.
Andrew Brislen, M.D.
Alfred Faber, M.D.
David Fox, M.D.
Robert Freeark, M.D.
Jack Gibbs, M.D.
Allan Goslin, M.D.
Eugene Hoban, M.D.
Eugene Johnson, M.D.
Morgan Meyer, M.D.
Thomas A. Reardon, M.D.
George Shropshear, M.D.
Donald Stehr, M.D.
Philip Thomsen, M.D.

Clinics for crippled children for January

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for January by the University of Illinois, Division of Services for Crippled Children. The Division will hold 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing services. There will be four special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

January—

5 Hinsdale—Hinsdale Sanitarium
6 Sterling—Community General Hospital
6 Flora—Clay County Hospital
6 Cairo—Public Health Department
11 Peoria—St. Francis Children's Hospital
11 E. St. Louis—Christian Welfare Hospital
12 Joliet—St. Joseph's Hospital
12 Champaign-Urbana—McKinley Hospital
13 Springfield—St. John's Hospital
13 Macomb—McDonough District Hospital
14 Chicago Heights Cardiac—St. James Hospital
18 Quincy—Blessing Hospital
18 Rock Island Area General—Moline Public Hospital
19 Evergreen Park—Little Company of Mary Hospital
20 Elmhurst Cardiac—Memorial Hospital of DuPage County
20 Decatur—Decatur Memorial Hospital
20 Rockford—Rockford Memorial Hospital
24 Peoria Cardiac—St. Francis Children's Hospital
25 Peoria—St. Francis Children's Hospital
26 Elgin—Sherman Hospital
26 Springfield Pediatric Neurological—Diocesan Center
26 Centralia—St. Mary's Hospital
26 Mt. Vernon—Park Avenue Baptist Church
28 Chicago Heights Cardiac—St. James Hospital

Abstracts of Board actions

(Continued from page 571)

and Bylaws which appeared in the October "Reference Issue" of the **Illinois Medical Journal.** He also reported that a general revision of the bylaws is being studied with a view to reducing overall size and clearing up some ambiguities.

Fee Splitting

Legal Counsel Frank Pfeifer informed the Board that H. B. 61, passed by the General Assembly last spring to outlaw fee splitting, seems to be working in the opposite direction from which it was intended and is legalizing fee splitting by allowing both the surgeon and the referring physician to bill for post-operative care. The Board pointed out that unethical conduct of physicians should be handled by Peer Review and through Ethical Relations Committees.

Task Force on Physician Shortage

Charged with the responsibility of providing a response to Senate Resolution No. 119, which calls for solutions to the physician maldistribution problem in Illinois, the Task Force brought several recommendations to the Board for consideration.

Dr. Lees said that it was the intention of the task force to have members of the legislature meet with the ISMS Council on Education and Manpower to hammer out a practical program based on some of these recommendations and those expressed by individual members of the Board.

Kidney Disease Detection Protocol

On recommendation of its Council on Environmental and Community Health, the Board endorsed the protocol for kidney disease detection developed by the Kidney Foundation of Illinois.

Student Loan Fund Bolstered

The Board of Trustees approved a loan of $20,000 to the Rural Student Loan Fund to maintain the program until such time as repayments by individuals equal new loans made. The Illinois Agricultural Association is expected to loan the fund an equal amount for a period estimated to be five years. The fund became depleted in recent years when the loan repayment schedule was extended to five years from graduation and increasing numbers of borrowers applied for loans. The ISMS Board of Trustees withheld this financial support pending a report from the University of Illinois on the program's efficacy. The now-released report states that the . . ."program has resulted in an increased number of general practitioners practicing in Illinois outside of Cook County. The effect is especially pronounced for areas which are truly rural."

Continuing Medical Education

The Board approved a Council on Education and Manpower recommendation that a grant application be developed and submitted to the Illinois Regional Medical Program for employment of an individual to conduct motivational research in the concern of self-assessment and in delivery of programs in continuing education. In a correlated action, an Ad Hoc Committee to Organize an Independent Statewide Council on Continuing Medical Education recommended that this grant application stipulate the individual employed should be approved by the independent council's board of directors consisting of a representative of each medical school in Illinois plus an equal number of physicians to be appointed by ISMS. Office space will be provided initially by ISMS.

Abstracts of Board actions

Monitoring Rights of Insurance Committee

The Board of Trustees reaffirmed the right of the Committee on Insurance to receive information on each application and claim under the ISMS malpractice insurance program in order to properly monitor the program in terms of eligibility and protection afforded to members in relation to premium costs. In a correlated action, the Board approved an Insurance Committee request that the Chicago Medical Society be asked to appoint an official liaison representative to the committee, inasmuch as CMS has recently adopted a policy statement which says, "The Chicago Medical Society does not believe in fragmenting the professional liability market in Illinois and supports the current Illinois State Medical Society program."

Medicine & Religion

The Board approved a request from the Committee on Medicine & Religion that $200 be added to its 1972 budget to cover expenses for a postgraduate seminar similar to the one on "Death and Dying" that was held during the last annual meeting.

Comprehensive Health Planning

The Task Force on Comprehensive Health Planning has been granted approval to conduct a series of conferences for physicians to:

A. Update physicians on the purpose, functions and objective of CHP, encourage them to get involved in their local agencies, and to show how they and their county medical society can guide CHP activities locally.
B. Explain the Governor's new regionalization plan, its effect on local CHP, and what it will mean to emerging foundations for medical care.
C. Inform them about the regional trauma centers and how the centers relate to their particular region and hospital.

Multiphasic Screening

The Board has endorsed a revised statement on multiphasic screening as an extension of services available to physicians. The new version, developed by the Council on Environmental and Community Health conforms to similar statements of the AMA and the American Society of Clinical Pathologists. It will be presented in resolution form to the 1972 House of Delegates for adoption as policy.

Minimum Standards for Ambulance Service

The Board concurred with a recommendation of the Council on Environmental and Community Health and its Public Safety Committee that until such time as the Governor's statewide trauma plan is fully implemented, current ambulance services should be maintained to complement this plan without an abrupt termination of service. The action follows an evaluation of the situation that would exist if federal standards were required of all ambulances immediately.

Over-Utilization of DVR Program

In response to House of Delegates action calling for an investigation of the Division of Vocational Rehabilitation, the Advisory Committee to DVR and the Council on Economics and Peer Review have asked the Board to seek specific examples of DVR over-utilization from county medical societies. The Board agreed.

Peer Review Guidelines to be Revised

The Board of Trustees approved a Council on Economics and Peer Review request to develop additional peer review guidelines that would spell out what type of cases are to be reviewed. This would discourage insurance carriers from using peer review committees merely to resolve minor fee disputes.

In other action, the Board approved the Council's recommendation that insurance carriers submitting cases of disputed fees for review should substantiate the fee profile data provided by the carrier really reflects the usual and customary charges in the area. Also that health insurance carriers be asked not to send claim forms containing medical information to any third party without prior approval of the physician or the patient involved.

Peer Review in Care of the Aging

In a follow-up action to a resolution adopted by the 1971 House of Delegates regarding indiscriminate moving of the elderly from nursing homes, the Board approved a recommendation from the ISMS Committee on Aging that a letter be written to appropriate state officials—including Dr. Franklin D. Yoder, Public Health director—asking that:

> "The attending physician's professional judgment and written recommendation regarding the level of care needed for a public aid patient after recovery from an illness shall not be disregarded or overruled by the state unless the question is submitted to adequate peer review and the attending physician notified."

Guidelines for Contract Care

The Board of Trustees gave approval to the Council on Social and Medical Services to write county medical societies, hospital administrators and medical staffs explaining that its recently published "Guidelines for Liaison with Private Firms Which Provide Emergency Health Care of Contract" was not meant to imply that the only firm mentioned in a covering letter suffered from shortcomings listed.

Alcoholism

The Council on Mental Health and Addiction and its Committee on Alcoholism recommended that Resolution 71M-12 be rejected since it calls for an abridgement of individual rights through mandatory hospitalization of alcoholics. The Board of Trustees concurred and directed the Council to report its recommendation back to the House. The Board also directed the Governmental Affairs Council to review model legislation patterned after the Massachusetts Alcoholism Treatment Act and report its recommendations back to the Board.

Control of Amphetamines

Although some medical organizations have officially denounced any prescribing of amphetamines in an effort to control their abuse, the ISMS Narcotics Committee suggests that "judicious use and prescription of amphetamines be maintained only for specific proven medical need, and that other stimulant drugs be considered likewise." It was pointed out to the Board of Trustees that amphetamines have been moved from Schedule III to Schedule II in both the federal and state controlled substances acts and that the change requires triplicate prescription forms be used. The Board approved a recommendation from the Council on Mental Health and Addiction objecting to the required use of the triplicate form for prescribing amphetamines or oxyzines, although in agreement that such substances should be under Schedule II controls.

Abstracts of Board actions

Lead Poisoning

In an effort to control lead poisoning, the Council on Environmental and Community Health made the following recommendations, which have been accepted by the Board of Trustees:

A. Urge county medical societies to cooperate with the American Academy of Pediatrics in exploring effective programs for the prevention of lead poisoning in their areas.

B. Endorse and urge prompt implementation of Public Law 91-695, which provides grants for the detection, treatment and elimination of lead-base paint poisoning, federal demonstration and research programs, and prohibits the use of lead-base paint in future federal construction and rehabilitation of residential buildings.

C. Make every effort to inform physicians on the severity of the problem and cooperate with the Illinois Department of Public Health in its new public education campaign on lead poisoning prevention.

D. Forward to the Director of the Illinois Bureau of the Budget a recommendation that sufficient funding be made available to the IDPH to allow completion of necessary testing for lead poisoning and that additional funding be provided to allow the blood samples from this program to be used to test levels of immunity to communicable diseases.

In memoriam

It is with deep remorse that we report the untimely death of *Timothy D. Selleck,* director of the ISMS Governmental Affairs Division. The crash of a Chicago and Southern commuter airline outside of Peoria, October 21, claimed his life along with 15 others.

Mr. Selleck, aged 26, had been with the medical society for more than two years, and served as Division director for the past year and a half. Prior to joining ISMS, he was assistant to the Speaker of the Illinois House of Representatives. A graduate of the University of Illinois, Mr. Selleck was the youngest lobbyist ever registered in Springfield.

He is survived by his parents, Mr. and Mrs. Poul Olsen of Park Ridge, a sister and a brother.



Additional information available to the profession on request.

Eli Lilly and Company • Indianapolis, Indiana 46206

Lilly

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Sen. Percy Praises HASP

HASP was praised before the United States Senate recently by Illinois Sen. Percy. He described HASP as a "sound program whose success is dependent upon the full cooperation of Illinois doctors in certifying the patient's need for hospital treatment. Percy said "Congress should be aware of the excellent support which Illinois doctors have given to the State's plan."

(Editor's note: On this point the Senator's source of information was erroneous. HASP is a creation of the Illinois Foundation for Medical Care . . . not of the State of Illinois.)

1st areawide Trauma Center named

St. Joseph Hospital in Joliet became the first areawide Trauma Center in the state when it was selected by the Will-Grundy Comprehensive Health Planning Council. This center will join a statewide plan to provide emergency medical services to the critically injured patient. The state plan calls for three levels of trauma centers: local, areawide and regional. Eight regional centers affiliated with universities are already functioning in the state with one additional center still to be selected.

Hospital, medical staff Accreditation workshops set

Two workshops to study new hospital and medical staff accreditation standards will be held in Illinois during April, 1972. Sponsored by the Joint Commission on Accreditation of Hospitals, the workshops will focus on new JCAH standards which became effective on July 1, 1971.

The program will be arranged so that physicians need attend only the first day of the one and one-half day workshops. The first workshop will be held on Thursday and Friday, April 6-7, at the Champaign-Urbana Ramada Inn for the benefit of downstate registrants. An identical workshop will be held the following week, Wednesday and Thursday, April 12-13, at the LaSalle Hotel in Chicago. More information, including registration blanks, will be mailed to all ISMS members early in 1972.

Our world is dying

- We are fouling our streams, rivers and lakes. The sea is next. We are burying ourselves under 7 million scrapped cars, 30 million tons of waste paper, 48 million discarded cans and 28 billion bottles and jars a year.
- A million tons of garbage pile up each day.
- The air we breathe circles the earth 40 times a year, and America contributes 140 million tons of pollutants:
 - —90 million tons come from cars (we burn more gasoline than the rest of the world combined).
 - —15 million tons from electric-power generation (1/3 of the world's total).
 - —In Chicago, an average of 43 tons of dirt falls on each square mile per month.
- Noise, straining our lives, doubles in volume every ten years.
- There are 5,500 Americans born each day—100 million more by the year 2000.
- We already consume and waste more than any other people.
- We flatten our hills, fill our bays, blitz our wilderness. THE QUALITY DRAINS FROM OUR LIVES. . . .



new pharmaceutical specialties

by paul dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

NEW SINGLE CHEMICALS

DARVON-N Analgesic-non-narcotic ℞
Manufacturer: Lilly
Nonproprietary name: Propoxphene napsylate
Indications: For relief of mild to moderate pain
Contradications: Hypersensitivity to drug. Should not be given to children.
Dosage: 100 mg. three or four times daily
Supplied: Tablets, 100 mg.

MINOCIN Broad spectrum antibiotic ℞
Manufacturer: Lederle
Nonproprietary name: Minocycline hydrochloride
Indications: To treat infections caused by organisms listed in package insert.
Contraindications: Hypersensitivity to any of the tetracyclines
Dosage: Initially 200 mg. followed by 100 mg. every 12 hours.
Supplied: Capsules, 100 mg.

DUPLICATE SINGLE PRODUCTS

AQUATENSEN Diuretic-Benzothiazides ℞
Manufacturer: Mallinckrodt
Nonproprietary name: Methylclothiazide
Indications: Treatment and control of edema and moderate hypertension.
Contraindications: Severe renal disease
Dosage: 2.5 mg. to 10 mg. once daily
Supplied: Tablet, 5 mg.

IPRENOL Bronchodilators ℞
Manufacturer: Vitarine
Nonproprietary name: Isoproterenol hydrochloride
Indications: For symptomatic relief of bronchial asthma emphysema and bronchitis.
Contraindications: In pre-existing cardiac arrhythmias associated with tachycardia.
Dosage: See package insert
Supplied: Solution 0.5%

KEFLEX ℞
Pediatric Drops Antibiotic
Manufacturer: Lilly
Nonproprietary name: Cephalexin monohydrate
Indications: Respiratory, urinary tract, skin and soft-tissue infections caused by organisms susceptible to its action.
Contraindications: Allergy to cephalosporins
Dosage: 25 to 50 mg. per kg.
Supplied: Powder, reconstituted each cc. contains 100 mg.

K-LYTE/CL Unclassified ℞
Manufacturer: Mead Johnson
Nonproprietary name: Potassium chloride
Indications: For therapy or prophylaxis of potassium deficiency.
Contraindications: Impaired renal function, Addison's disease or hyperkalemia.
Dosage: Adults: 1 dose (25 mEq. dissolved in 6 oz. cold H_2O two to four times daily).
Supplied: Powder, reconstituted each 6 oz. contains 25 mEq.

ROBITET Broad spectrum antibiotic ℞
Manufacturer: Robins
Nonproprietary name: Tetracycline hydrochloride
Indications: See package insert
Contraindications: Hypersensitivity to any tetracyclines
Dosage: Adults: 1 to 2 gms. divided into 4 equal doses.
Children: 25 to 50 mg./kg. of body weight divided into 4 equal doses.
Supplied: Capsules, 250 mg. and 500 mg.

SK-APAP Analgesics-non-narcotic o-t-c
Manufacturer: Smith Kline & French
Nonproprietary name: Acetaminophen
Supplied: Tablets, 325 mg.

New pharmaceutical specialties

SK-ESTROGENS Estrogens ℞
Manufacturer: Smith Kline & French
Nonproprietary name: Estrogenic substances conjugated
Supplied: Tablets, 0.3 mg.
0.625 mg.
1.25 mg.
2.50 mg.

DARVON-N ℞
with A.S.A. Analgesic-non-narcotic
Manufacturer: Lilly
Composition: Propoxphene napsylate 100 mg.
Aspirin 325 mg.
Indications: For relief of mild to moderate pain
Contraindication: Hypersensitivity to drug. Should not be used in children.
Dosage: 1 tablet three or four times daily
Supplied: Tablets, IDENTI-DOSE packages

E-CARPINE Eye Preparation ℞
Manufacturer: Alcon
Composition: Contains:
Ephinephrine bitartrate 0.5%
Pilocarpine HC1 1%, 2%, 3%, 4%, 6%
Indications: Chronic simple glaucoma
Contraindications: Narrow angle glaucoma or sensitivity to any of its components.
Dosage: One or two drops topically in eye(s) one to four times daily.
Supplied: Solution (Droptainer), 15 cc.

NEW DOSAGE FORMS

FLUOROPLEX Dermatological Preparation ℞
Manufacturer: G.S. Herbert
Nonproprietary name: Fluorouracil
Indications: Multiple actinic (solar) keratoses
Contraindications: Known hypersensitivity to any of the components of the drug.
Dosage: Apply cream twice daily
Supplied: Cream, 1%

NAVANE Ataraxics ℞
Manufacturer: Roerig
Nonproprietary name: Thiothixene hydrochloride
Indications: Acute schizophrenia
Contraindications: In patients with circulatory collapse, comatose states, central nervous depression due to any cause and blood dyscrasias.
Dosage: To be adjusted individually, maximum recommended dose 30 mg./day i.m.
Supplied: Vials, each cc. contains equivalent to 2 mg. of thiothixene.

ROBITET ℞
Syrup Broad spectrum antibiotic
Manufacturer: Robins
Nonproprietary name: Tetracycline hydrochloride
Indications: See package insert
Contraindications: Hypersensitivity to any tetracyclines
Dosage: Adults: 1 to 2 gms. divided into four equal doses.
Children: 25 to 50 mg./kg. of body weight divided into 4 equal doses.
Supplied: Syrup, each 5 cc. contains 125 mg.

SK-APAP Analgesics-non-narcotic o-t-c
Manufacturer: Smith Kline & French
Nonproprietary name: Acetaminophen
Supplied: Elixir, each 5 ml. contains 120 mg.

Obituaries

*__William H. Arnoff__, Los Altos, Calif., formerly of Skokie, died October 10, at the age of 51.

*__Martin E. Conway__, Aledo, died October 12, at the age of 63. He had served as medical advisor to the Mercer County Selective Service Board for more than 25 years at the time of his death.

*__Robert H. Dancey__, died October 7, at the age of 61. He was superintendent and medical director of the Mount Vernon State Tuberculosis Sanitarium.

*__John J. Marino__, Lincolnwood, died October 15, at the age of 51. He served as an assistant professor in the University of Illinois Medical School and was clinical instructor in cardiac surgery at Presbyterian-St. Lukes Hospital.

*__Alfred E. Slawinski__, Chicago, died October 8, at the age of 70. He was a physician and staff surgeon at St. Mary of Nazarene Hospital for 42 years.

* *ISMS member*
** *50 Year Club member*

what goes on

a guide to continuing education

January 6-9—American Society of Anesthesiologists

"Postgraduate Seminar in Anesthesiology"

For information write: The American Society of Anesthesiologists, 515 Busse Highway, Park Ridge, Illinois 60068

Playboy Plaza Hotel, Miami Beach, Fla.

January 12—University of Chicago, Div. of Biological Sciences and the Pritzker School of Medicine

"A New Look at Otological Problems"

This program will be limited to a consideration of relatively new developments in the diagnosis and treatment of old and familiar otological disorders and to the solution of newly developing problems. For registration and information write: Frontiers in Medicine, The University of Chicago, (BH Box 451) 950 E. 59th St., Chicago, Ill. 60637 or call (312) 947-5110.

Frank Billings Auditorium, 950 E. 59th St., Chicago, Ill.

January 12-13—University of Missouri-Columbia

"Symposium on Practical Obstetrics and Gynecology"

Topics include obstetric hemorrhage, amniotic fluid analysis for diagnosis of fetal maturity and intrauterine fetal welfare in pregnancies complicated by maternal Rh iso-immunization and diabetes, carcinoma of the endometrium and cervix, indications for hysterectomy and operative procedures for genital prolapse. For information write: University of Missouri—Columbia, School of Medicine, Committee on Continuing Education, M-175 Medical Center, Columbia, Missouri 65201

Columbia, Mo.

January 17-19—American College of Surgeons

"1972 Sectional Meeting"

All doctors of medicine may attend the meetings. Surgeons of outstanding ability will focus attention on newer ways of handling surgical problems through panels, symposia, "How-I-Do-It" clinics, scientific papers, and selected films. Each meeting features sessions in general surgery plus two or more surgical specialties. For information write: American College of Surgeons, 55 E. Erie St., Chicago, Ill. 60611

Sheraton-Four Ambassadors Hotel, Miami, Fla.

January 19-21—American College of Chest Physicians

"Intensive Respiratory Care for Nurses, Inhalation and Physical Therapists"

For information write: American College of Chest Physicians, 112 E. Chestnut St., Chicago, Ill. 60611

Salt Lake City, Utah

January 26-28 — Northwestern University Medical Center and Passavant Memorial Hospital

The Year in Internal Medicine—Postgraduate Course

Subjects discussed will include topics of current interest in hematology, oncology, the collagen diseases, cardiovascular disease, endocrinology, and gastroenterology.

Special emphasis will be placed on the application of new data from clinical and laboratory investigation to the problem of patient management. Many of the discussions will commence with a case presentation.

The full registration fee of $90 (lunches and cocktail party included) is payable at the time of registration. This sum will be refunded providing notice of cancellation is received in writing ten days prior to the opening of the course. Make checks payable to Passavant Memorial Hospital and mail to: The Year in Internal Medicine Passavant Memorial Hospital, 303 E. Superior St., Chicago 60611.

Offield Auditorium, Passavant Memorial Hospital, Chicago

The eye and learning disabilities

Learning disability and dyslexia require a multi-disciplinary approach from medicine, education and psychology in diagnosis and treatment.

THE PROBLEM of learning disability has become a matter of increasing public concern, which has led to exploitation by some practitioners of the normal concern of parents for the welfare of their children. A child's inability to read with understanding as a result of defects in processing visual symbols, a condition which has been called *dyslexia,* is a major obstacle to school learning and has far-reaching social and economic implications. The significance and magnitude of the problem have generated a proliferation of diagnostic and remedial procedures, many of which imply a relationship between visual function and learning.[1]

The eye and visual training in the treatment of dyslexia and associated learning disabilities have recently been reviewed* with the following conclusions by the American Academy of Pediatrics, the American Academy of Ophthalmology and Otolaryngology, and the American Association of Ophthalmology:

1. Learning disability and dyslexia, as well as other forms of school underachievement, require a multi-disciplinary approach from medicine, education, and psychology in diagnosis and treatment. *Eye care should never be instituted in isolation when a patient has a reading problem.* Children with learning disabilities have the same incidence of ocular abnormalities, e.g., refractive errors and muscle imbalance, as children who are normal achievers and reading at grade level.[2-4] These abnormalities should be corrected.
2. Since clues in word recognition are transmitted through the eyes to the brain, it has become common practice to attribute reading difficulties to subtle ocular abnormalities presumed to cause faulty visual perception. Studies have shown that *there is no peripheral eye defect which produces dyslexia and associated learning disabilities.*[5,6] Eye defects do not cause reversals of letters, words, or numbers.
3. No known scientific evidence supports claims for improving the academic abilities of learning-disabled or dyslexic children with treatment based solely on:
 a) visual training (muscle exercises, ocular pursuit, glasses),[7-12]
 b) neurologic organizational training (laterality training, balance board, perceptual training).[2-14]

Furthermore, such training has frequently resulted in unwarranted expense and has delayed proper instruction for the child.

4. Excluding correctable ocular defects, glasses have no value in the specific treatment of dyslexia or other learning problems. In fact, unnecessarily prescribed glasses may create a false sense of security that may delay needed treatment.
5. The teaching of learning-disabled and dyslexic children is a problem of educational

* *This statement was prepared by an ad hoc committee of the American Academy of Pediatrics, the American Academy of Opthalmology and Otolaryngology, and the American Association of Ophthalmology with the assistance of the President and the Past President of the Division for Children with Learning Disabilities. The Executive Committees and Councils of these organizations have approved this statement.*

This Joint organizational statement has also been approved by the Eye Committee of the Illinois State Med. Society.

science. No one approach is applicable to all children. A change in any variable may result in increased motivation of the child and reduced frustration. Parents should be made aware that mental level and psychological implications are contributing factors to a child's success or failure. Ophthalmologists and other medical specialists should offer their knowledge.

This may consist of the identification of specific defects, or simply early recognition. The precursors of learning disabilities can often be detected by three years of age. Since remediation may be more effective during the early years,[15] it is important for the physician to recognize the child with this problem and refer him to the appropriate service, if available, before he is of school age. Medical specialists may assist in bringing the child's potential to the best level, but the actual remedial educational procedures remain the responsibility of educators.

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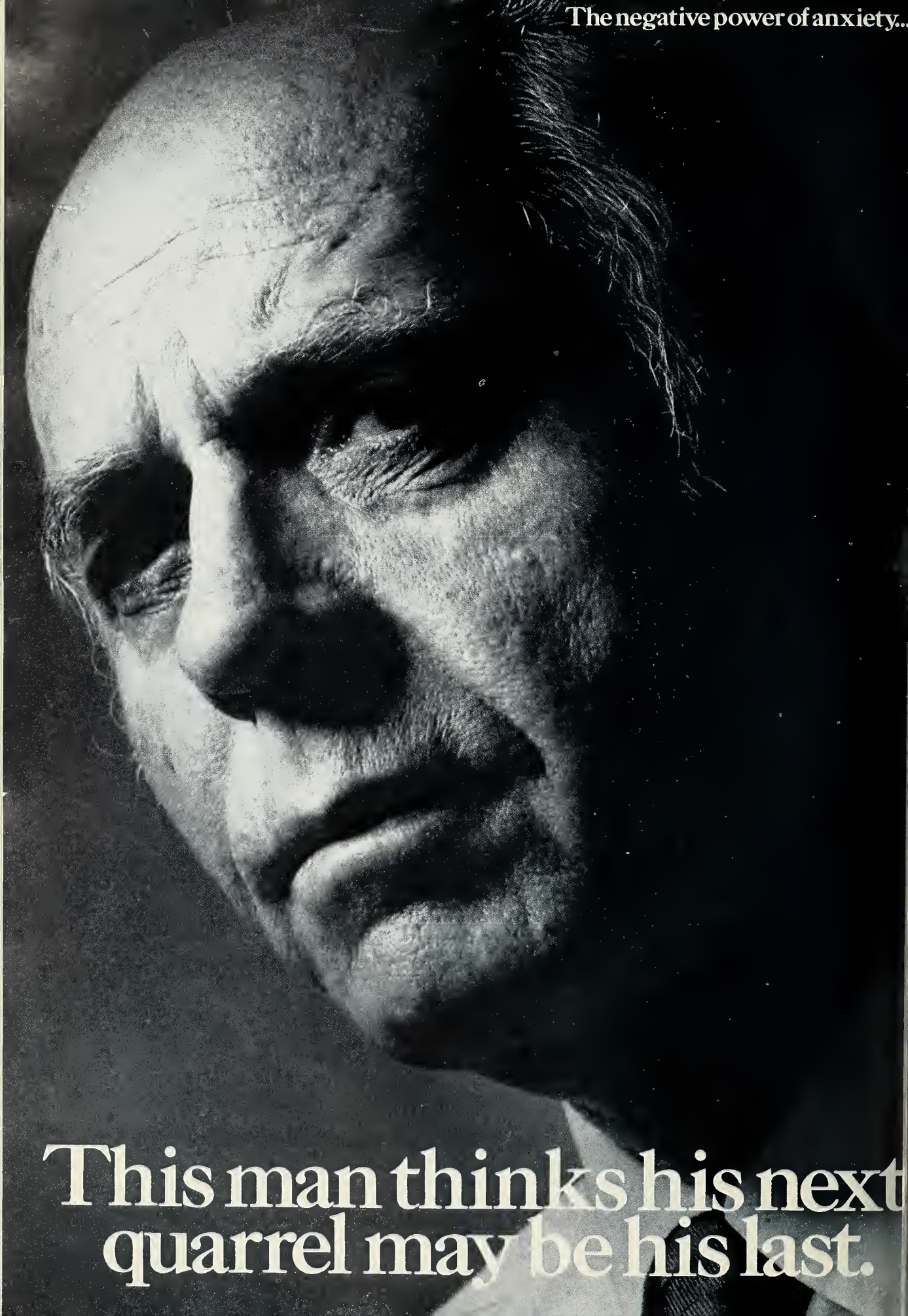
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Per diem

Edward F. MacNichol, Jr., Ph.D., had it made. He was "setting an example for all of us," commented the **LA Times** with excusable sarcasm. Every July and August, this $36,000-a-year head of the National Institute of Neurological Diseases & Stroke retired to his home on Cape Cod, drew his full salary and billed the government $25 a day travel expenses. As an excuse, he said the "relaxed atmosphere" enabled him "to work longer hours with less fatigue." Then he went fishing. Said the **LA Times**, "man who runs important national health agency should keep fit." When the press questioned the propriety, if not the legality, of the habit, MacNichol promised to put all the expense money he'd received for the past three years into escrow pending official ruling. (**Medical News Report** 3:40 Oct. 11, 1971.)


The negative power of anxiety...
This man thinks his next
quarrel may be his last.

For the hypertensive patient, severe symptoms may be intensified and aggravated by emotional overreaction to stress. Acutely aware of the adverse impact his emotions may have on the course of his life, the hypertensive patient's anxieties may be increased.

Adjunctive use of Libritabs may be of significant value in reducing excessive anxiety, which can induce adverse biochemical and physiological changes related to the vascular system and, by so doing, jeopardize management of the disease itself.

Libritabs (chlordiazepoxide) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is a significant component of the clinical profile.

Libritabs is especially well suited for extended use because of its wide margin of safety. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See full prescribing information.) Moreover, the antianxiety benefits of Libritabs are generally maintained without diminution of effect or need for increase in dosage. When treatment is prolonged, periodic blood counts and liver function tests are advisable.

Libritabs (chlordiazepoxide) permits flexible, individualized therapy through its three oral dosage strengths.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

To relieve excessive anxiety in hypertensive patients

adjunctive

Libritabs®

(chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets

t.i.d./q.i.d.

up to 100 mg daily for severe anxiety

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Diabetes mellitus

(Continued from page 576)

Summary

Neurologic complications of diabetes mellitus are common in adults and fairly common, when sought by electrical means, in children. Atonic bladders common in adult diabetics with neuropathy are rare in children. A 20-year-old male and 19-year-old male are the only reported patients with such a complication. A 18-year-old female is reported in this paper with peripheral neuropathy and autonomic neuropathy with constipation and an atonic bladder. The literature on diabetic neuropathy in children has been reviewed.

References

References for this article can be obtained by writing to: *Illinois Medical Journal,* 360 N. Michigan Avenue, Chicago, Ill. 60601.

the view box

(Continued from page 577)

DIAGNOSIS: *Thoracic asphyxiating dystrophy.* Thoracic asphyxiating dystrophy is a generalized skeletal abnormality with major involvement of the cartilaginous thoracic cage resulting in a narrow and relatively immobile chest. The disturbed ossification in the costochondral junctions leads to the development of the short, poorly formed, stubby ribs with irregular cartilage growth. The relatively small fixed thoracic cage accounts for poor air exchange and the proneness of these patients to recurrent pulmonary infections. Associated abnormalities include polydactyly, abnormalities of the pelvis, short and stubby extremities, dental abnormalities and renal abnormalities.

ekg of the month

(Continued from page 582)

Answers:

A. 3. Left bundle branch block, complete (LBBB). The QRS is prolonged to 0.12 seconds. (Normal 0.06 to 0.10 seconds). The QRS complexes are slurred. Q waves are absent suggesting abnormal depolarization.

B. 5. All of the statements may be correct. Many of the asymptomatic patients with LBBB may have no significant clinical heart disease. Some give history of previous diphtheria or viral disease. Most have normal exercise tolerance. On physical examination second heart sound has reversed splitting. The prognosis is good.

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

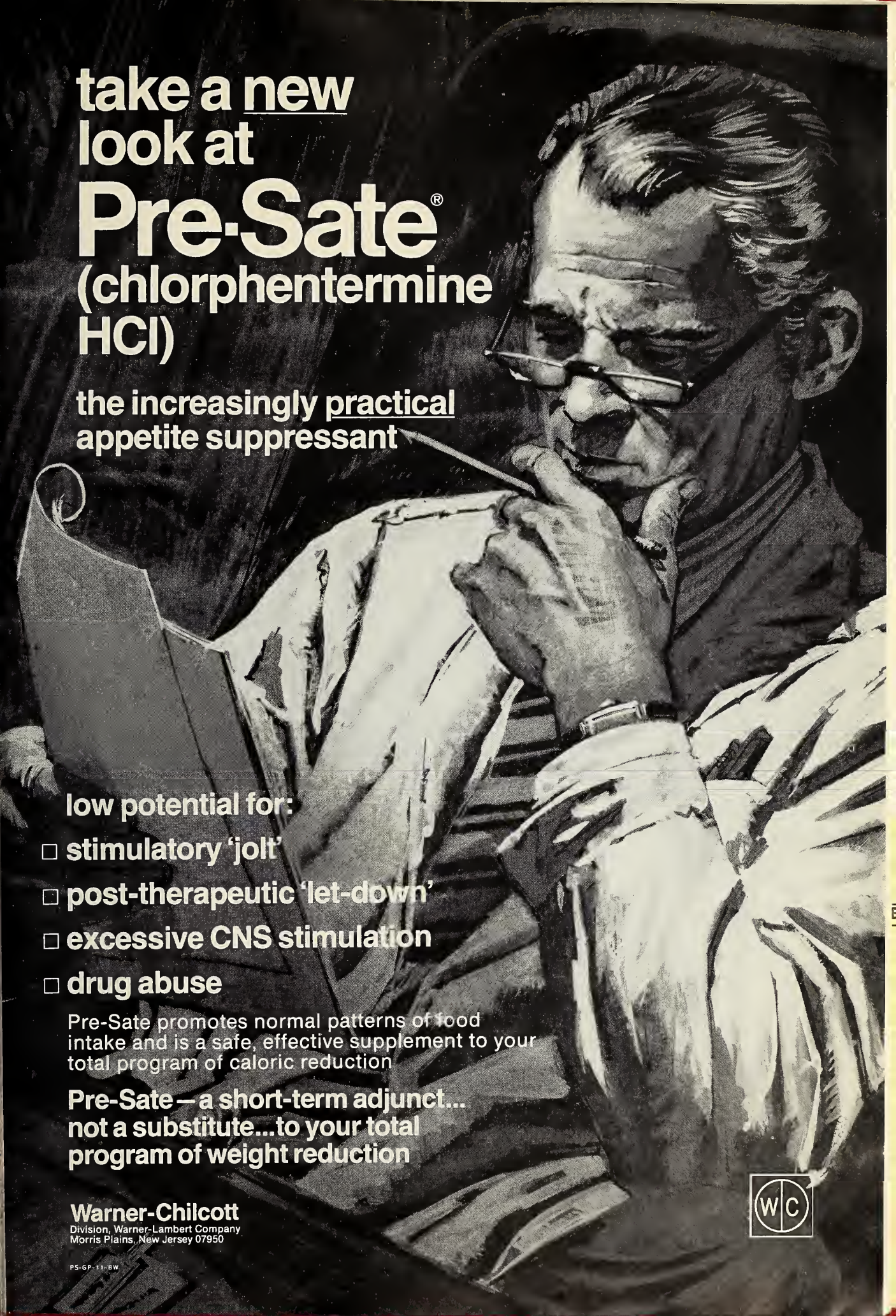
Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

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Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

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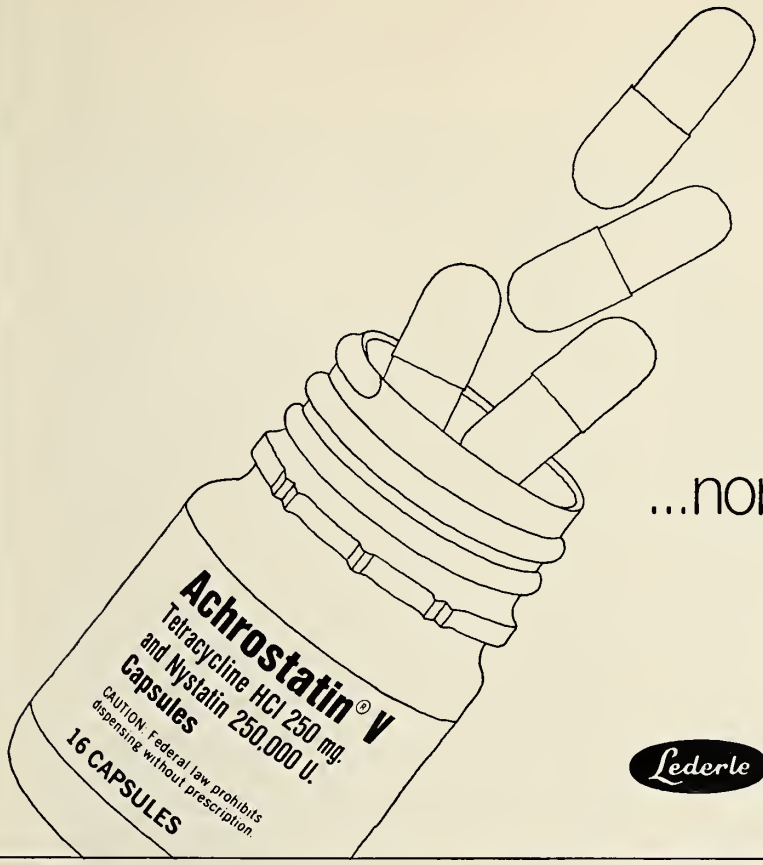
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Corrections

Corrections for material appearing in Volume 140 of the *IMJ*:

OCTOBER: *Page 365*
Add *Rockford Memorial Hospital* to listing of "Approved Schools of X-Ray Technology"
Page 375
Illinois State Pediatric Institute address is *1640 West Roosevelt Road, Chicago 60606*

NOVEMBER: *Page 489*
Corrections in biographical data on Simon Horenstein, M.D.: *Currently professor and chief of Neurology at Saint Louis University School of Medicine; and Dr. Horenstein was graduated from the University of Illinois College of Medicine.*



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Practice management

(Continued from page 606)

doctors, however, have told me that they were just as happy when they were living on less money.

Disability insurance

As the wage earner in the family, you need some sort of protection against disablement. Just how much would it cost to support you and your family in that event? Where would you derive the funds necessary to finance the cost? Most often you would finance the cost through the proceeds of disability insurance. Have you really figured what funds you would need in the event of your disability? Is the waiting period proper for your situation? For how long would you receive payments in the event of your disability? How is disability defined? These are all factors in determining that you have the proper coverage, both in quantity and quality of coverage. Certainly one is concerned about providing for his family in the event of his untimely death. Have you ever figured this out for yourself—or has a life insurance salesman offered a generous formula? How much would be needed? Have you considered that some of the amounts needed might be funded by social security or from other investment assets which you have or will accumulate? In planning an insurance program have you considered that it is far more likely that you will live than you will die—that your need is far greater in the early years than in the later years when the children are through school? Have you considered that the cash values developed in life insurance policies may be eroded by inflation? In my experience most doctors have a hodge-podge of life insurance policies which were purchased from different agents, perhaps in self-defense, which bear little relationship to actual need.

Savings and investment program

To have a savings and investment program is the gist of getting ahead financially. Funds developed can be used to aid in educational costs, to reduce the amount of life or disability insurance needed or to provide the assets for your possible retirement. Few, if any, of our doctors have expressed a desire to retire at a specific age. Most, however, would like to be in a position to retire if they wished. They would like to be financially independent by the normal retirement time. Thereafter, they would work only because they wished to work—not because they were compeled to practice for financial reasons.

Only you can realistically determine your financial plan, but in any plan, the four basic need categories discussed above must be considered. Planning is required because no matter what you earn, there is seldom enough money to go around. Fortunately, however, your earnings are such that with good personal financial planning you can usually satisfy all the "needs" and still live comfortably. We know that a doctor who is secure financially is better able to concentrate on his practice and to enjoy his home life. Professional business consultants feel that a properly conceived and operable personal financial plan is just as fundamental to successful practice management as are good personnel, space, and systems.

Fund Drive reminder

More and more causes seem to need funds each year, and autumn is the open season for contributors. Deciding which to give to can be a problem; another is protecting your gift budget from phony solicitors. Here are some precautions worth remembering:

1. Give only to those whose activities and purposes are known to you. If a strange group sounds deserving, don't hesitate to demand details.
2. If you are not acquainted with the solicitor, request identification.
3. Hold back if he uses high pressure or is too persistent.
4. Legitimate charities welcome your check. Any angling for cash should ring an alarm.
5. Don't let big names impress you. Maybe someone is misusing yours!
6. Beware of telephone touches: insist on a letter or personal call.
7. In the absence of a reliable statement or other proof, don't assume your donation is deductible.

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